



medisoft®

Getting Started with
Medisoft 17
User Guide
November 2010

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Software registration required

You must register your Medisoft program. Full instructions on how to register are part of the installation instructions you printed out prior to installing the program.

Proof of ownership

KEEP YOUR SERIALIZED SOFTWARE, even if damaged or obsolete. It is your proof of ownership.

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Preface

Where to Find Help

Online Help

No matter where you are in Medisoft, help is not far away. Access the online Help screens to find detailed information on each feature in the program. Online Help is available in two different ways:

Context-Sensitive Help

For help in a particular part of the program, click the area for which you need help and press F1. The help topic for that area should appear.

Main Help File

To access the main help file, click the Help menu and select Medisoft Help.

The main help file will appear displaying the Contents tab. Use the Contents tab to view categorized topics for the program. Use the Index and Search tabs to find out additional or specific information about the program.

Medisoft Knowledge Base

The Knowledge Base is a searchable online database containing technical information relevant to the use of Medisoft products. To access the Knowledge Base, go to the following web site:

<http://www.medisoft.com/kb>

When accessed, you can search for information concerning Medisoft products. All current technical information is contained in the Knowledge Base.

Training

There are various training options available. Please contact your local Value-Added Reseller or the Medisoft Sales Department at 800-333-4747 for information concerning these options.

Independent Value-Added Resellers

There are Value-Added Resellers in your market area who are knowledgeable and efficient in selling, installing, troubleshooting, and supporting your Medisoft program. You can contact the Medisoft Sales Department at 800-333-4747 for the name of a qualified Value-Added Reseller in your area to give you hands-on help or search the Medisoft website at www.medisoft.com for a reseller in your area.

Technical Support

Call Support at (800) 334-4006 between the hours of 8:00 a.m. and 8:00 p.m Eastern Standard Time. You will hold for a technical support representative who has specific knowledge about the issue for which you are calling.

Getting Started with Medisoft

The topics featured in the Getting Started with Medisoft book are intended to help you set up your practice, begin entering transactions, create claims, and apply payments. The topics in this section do not completely document Medisoft. For more information, look up related information in the Search field of the Help file and access other parts of the Help system.

New in this Version

Enhancement: ARRA Reporting

Medisoft 17 includes four new reports to help you to remain compliant with upcoming ARRA requirements, specifically the requirements for electronically verifying the eligibility of your patients for insurance and for electronically sending claims to insurance providers. These include:

- Appointment Eligibility Analysis - Detail
- Appointment Eligibility Analysis - Summary
- Electronic Claims Analysis - Detail
- Electronic Claims Analysis - Summary

Each of these reports offers several filters for controlling the information that shows. In addition, several summary values appear on each report so that you can see at a glance the information you need to verify that you are meeting ARRA requirements.

Enhancement: ARRA Audit

Medisoft 17 includes a feature that allows you to track reporting and exporting for ARRA when you generate audit reports. A new option on the Audit tab in Program Options allows you to turn this feature on or off. It is turned on by default. Certain reports or grids that are printed or saved to disk will be audited.

Note: Previewed reports will not be audited.

The following types of information are included as part of the ARRA Audit:

- Data grids
- Custom reports, including claims and statements

When printed from either Transaction Entry or Statement Management, but not the Report menu or Report Designer.

- Medisoft reports
- Office Hours data
- Final Draft reports or data printed or saved to disk
- Internal reports
- Statements
- Eligibility information

BillFlash

Medisoft Advanced and Network Professional programs only.

Statements sent to patients electronically through Medisoft will now use BillFlash. You can enroll within Medisoft now, as well as upload your statement files directly from Medisoft automatically. You can view and approve the uploads at BillFlash by clicking links from within

Medisoft, and BillFlash will print and mail your statements to your patients. For more information on BillFlash, to get more detail, and learn how to enroll, go to BillFlash

Within Medisoft, you can control several aspects of what prints on your statements, including which credit cards you accept, service messages you want to print, printing of account summaries and aging, and printing up to six messages you want to appear on statements. For more information, go to Program Options - BillFlash tab

Options on the Activities, Bill Flash menu allow you to enroll with BillFlash, view and approve statements that have uploaded to BillFlash, see your account settings at BillFlash, and view reports, such as the Disposition report. Each one of these menu options will open a different page at the BillFlash website.

Several windows in Medisoft have quick access to the eView page of the BillFlash website via a new **View eStatements** button. In addition, when a patient is selected and **Ctrl + F7** is clicked, the eView page will open for any statements for that patient. These windows are:

- Patient List

The screenshot shows the 'Patient / Guarantor: Bordon, John' window in Medisoft. The window has a blue title bar and a light blue background. It is divided into several sections. At the top, there are tabs for 'Payment Plan' (set to 'Custom') and 'Name, Address' (selected). Below the tabs, there is a 'Chart Number' field with the value 'BORJO000' and an 'Inactive' checkbox. The 'Name, Address' section contains fields for 'Last Name' (Bordon), 'First Name' (John), 'Middle Name', 'Street' (777 Hardway Ln.), 'City' (Scottsdale), 'State' (AZ), 'Zip Code' (85777), and 'Country' (USA). Below this, there are fields for 'E-Mail', 'Home' (434)777-1234, 'Work', 'Cell', 'Fax', and 'Other'. The 'Demographics' section at the bottom includes 'Birth Date' (1/20/1972), 'Sex' (Male), 'Birth Weight' (0), 'Units', 'Social Security' (444-55-6666), 'Entity Type' (Person), 'Race', 'Ethnicity', 'Language', and 'Death Date'. On the right side of the window, there is a vertical toolbar with buttons for 'Save', 'Cancel', 'Help', 'Set Default', 'Copy Address...', 'Appointments', and 'View eStatements'. The 'View eStatements' button is highlighted with a red rectangular box.

- New/Edit Case
- Quick Ledger
- Guarantor Ledger
- Apply Payments (through Transaction Entry)
- Collection List/Tickler
- Edit Statements

Statement: 4

Statement: 4 Statement Created: 12/22/2003

Guarantor: CATSA000 **Catera, Sammy**

Remainder: \$71.00

General Transactions Comment

Status

☐ Hold

☒ Ready to Send

☐ Sent

☐ Failed

☐ Challenge

☐ Done

Billing Method

☐ Paper

☐ Electronic

Type: R - Remainder

Initial Billing Date:

Batch: 0

Submission Count: 0

Billing Date:

Save

Cancel

View eStatements

Help

- Deposit List
- Apply Payments
- Transaction Entry (note that Calculate Totals has been moved.)

Transaction Entry

Chart: TES00000 Test

Case: 1 Test

Last Payment Date:

Last Payment Amount: \$0.00

Last Visit Date:

Visit: 0 of 0

Global Coverage Until:

Charges:

Aetna Patient

Co-pay Overdue: \$0.00

0-30	31-60	61-90	91+
0.00	\$0.00	\$0.00	\$0.00

Total: \$0.00

Policy Copay: 0.00 OA:

Annual Deductible: 0.00 YTD:

Charges:

Adjustments:

Subtotal:

Payment:

Balance:

Account Total: \$0.00

☐ Calculate Totals

Case Number	Entry Number	PP	Claim Number	Date Fr...	Date To	Document Number	Description	Attending Provider

New Delete MultiLink Note EDI Notes Details

Payments, Adjustments, And Comments:

Date	Pay/Adj Code	Who Paid	Description	Check Number	Amount
9/13/201					0.00

Apply New Delete Note

Update All Quick Receipt Print Receipt Print Claim **View eStatements** Close Save Transactions

HIPAA X12 Version 5010

The following are changes made to Medisoft 17 to accommodate the upcoming change from the Health Insurance Portability and Accountability Act (HIPAA) Accredited Standards Committee

(ASC) X12 version 4010A1 to ASC X12 version 5010 and National Council for Prescription Drug Programs (NCPDP) version 5.1 to NCPDP version D.0.5010. HIPAA X12 version 5010 and NCPDP version D.0 are new sets of standards that regulate the electronic transmission of specific healthcare transactions, including eligibility, claim status, referrals, claims, and remittances. Covered entities, such as health plans, healthcare clearinghouses, and healthcare providers, are required to conform to HIPAA 5010 standards.

These changes include new windows/tabs, restructured windows or moved fields, menu changes, new fields, additional options, and other changes.

New Windows or Tabs

There are three new windows or tabs.

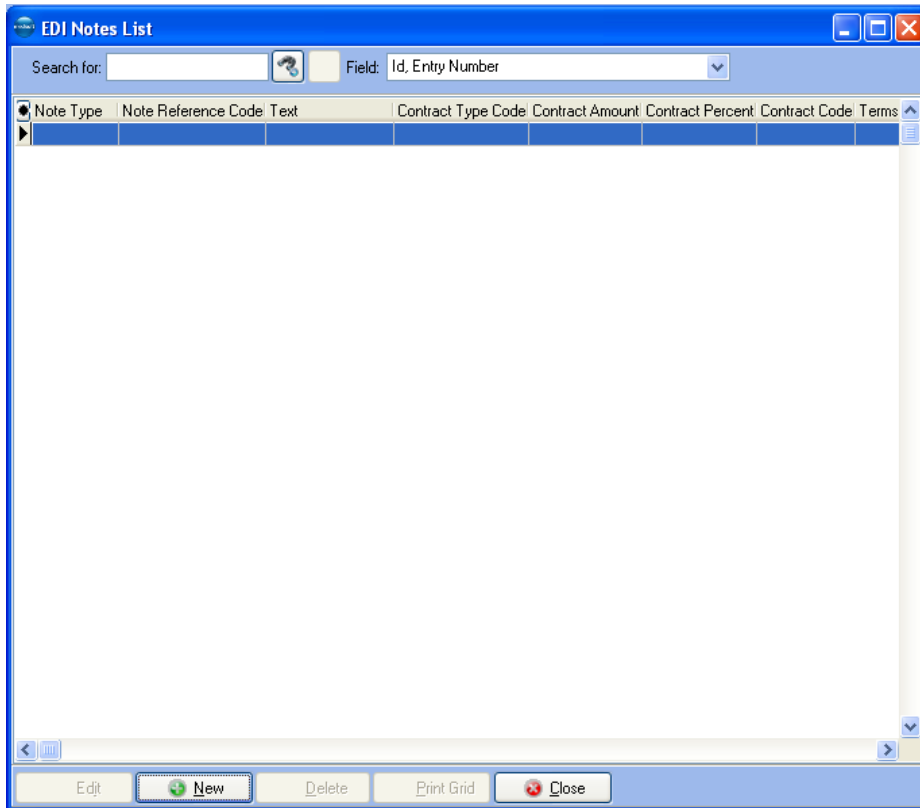
Edit Claim window, new EDI Note tab.(for Claim level notes)

The **EDI Note** tab has been added to the Edit Claim window. Information on this tab is pulled from the Case Window, Comment tab. This tab allows you to change various note information at the claim level so it does not affect the data in the case record itself.

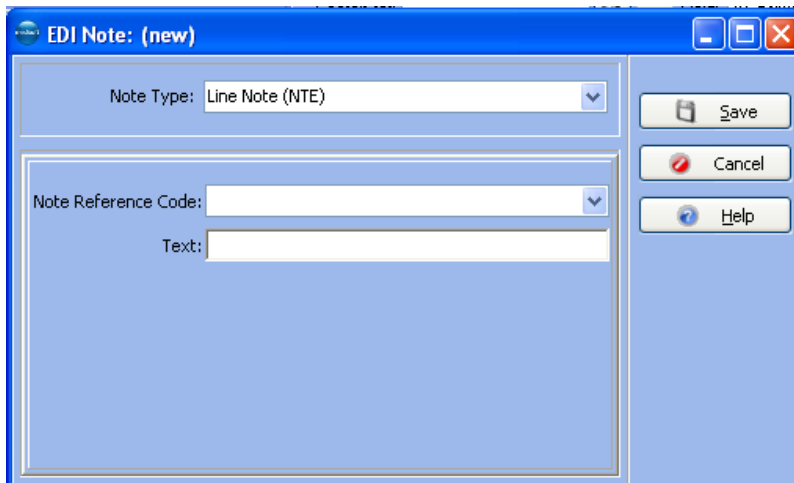
For more information on this tab, see EDI Note tab

EDI Notes and List windows (for Transaction Line Item notes)

A new EDI Notes window will allow you to enter notes of various types for electronic transmission. The corresponding List window will open when the new EDI Notes button is clicked during Transaction Entry, Patient or Guarantor Ledger, or Unprocessed Transactions.



From this window, you can create or edit EDI Notes using the EDI Note window.



You can use this window to enter four different types of notes. Depending on your selection in the Note Type field, the fields will change. For more information, see EDI Notes. This change eliminates the need to type notes with delimiters in the Transaction Documentation window.

On the Transaction Entry and Patient Ledger windows, you can see if there is an EDI note associated with a particular line item by adding the EDI Notes column, using the Grid Columns window.

Note: This column will NOT display by default. When you add it, the Caption will be EDINotes and the Width will be 4; however, after clicking it, the Caption will simply be E with a width of 2. If you attempt to change it back to EDINotes, it will return to E automatically.

Warning: You must close any open EDI Notes windows before you can return to Transaction Entry, Unprocessed Transactions, or the Ledger windows.

Restructured windows and moved fields

Several fields have been moved and windows have been restructured and rearranged to accommodate the moved fields.

- **Allergies and Notes**, as well as **EDI notes**, have been moved to the Comments tab of the Case window.

Case: AGADW000 Again, Dwight [Back Pain]

Personal | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | Condition | Miscellaneous | Medicaid and Tricare | Multimedia | **Comment** | EDI | Custom One

Allergies and Notes

EDI Notes

Note Reference Code:

Certification Narrative (CER)

Text:

Contract Information

Contract Type Code: Capitalated (05) Contract Amount:

Contract Percent: 10 Contract Code: test

Terms Discount Percent: 10 Contract Version: test

Comment

Patient Information

Name: Again, Dwight Home Phone: 434-5777

Address: 1742 N. 83rd Ave. Work Phone:

Phoenix, AZ Cell Phone:

85021 Date of Birth: 3/30/1932

Case 17

Save Cancel Help UB04... Eligibility... Face Sheet Set Default

- **Condition Codes** have been moved from the UB04 window, FL 4 to 41 tab to the Condition tab of the Case window to accommodate changes that allow condition codes to be used in professional claims.

Condition Codes will not be copied if the user uses Copy Case.

Case: AGADW000 Again, Dwight [Back Pain]

Miscellaneous | Medicaid and Tricare | Multimedia | Comment | EDI | Custom One

Personal | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | **Condition**

Injury/Illness/LMP Date: Date Similar Symptoms:

Illness Indicator: ☐ Same/Similar Symptoms

Initial Treatment Date: ☐ Employment Related

☐ Emergency

Accident

Related To: State:

Nature Of:

Last X-Ray Date:

Death/Status

Dates

From: To:

Unable to Work:

Total Disability:

Partial Disability:

Hospitalization:

Workers' Compensation

Return To Work Indicator:

Percent of Disability:

Last Worked Date:

☐ Pregnant

Estimated Date of Birth:

Date Assumed Care:

Date Relinquished Care:

Condition Codes

1. 2. 3. 4. 5. 6.

7. 8. 9. 10. 11. 12.

Patient Information

Name: Again, Dwight Home Phone: 434-5777

Address: 1742 N. 83rd Ave. Work Phone:

Phoenix, AZ Cell Phone:

85021 Date of Birth: 3/30/1932

Save Cancel Help

UB04... Eligibility... Face Sheet Set Default

Case 17

New Fields added

Several new fields have been added throughout the program. Below is a table describing the window where the new field is located, the field name, and its purpose.

Window where the field is located	Field Name	Purpose
Practice Information, Practice Tab	Email	Enter the general email address for the practice.
Case Window, Case Policy 2 Tab	Medicare Secondary Reason	Allows you to specify the reason why Medicare coverage is secondary. Visible only if an insurance with Type of Medicare is selected.
Patient/Guarantor, Name, Address Tab	Date of Death	Enter the date on which the patient died, if necessary.
Patient/Guarantor, Name, Address Tab	Suffix	Allows you to enter a suffix for the patient's name, such as Jr. Windows that show the patient's name will now display the suffix as well.

Patient/Guarantor, Name, Address Tab	Race	Select the patient's race.
Patient/Guarantor, Name, Address Tab	Ethnicity	Select the patient's ethnicity.
Case Window, Medicare and Tricare Tab	Special Program Code	Allows you to select any special program from the drop-down list.
Provider Window, Address Tab	Middle Name	Allows you to enter the middle name of the provider.
Referring Provider Window, Address Tab	Middle Name	Allows you to enter the middle name of the referring provider.
Case Window, Policy 1, 2, and 3 Tabs	Group Name	Enter the group name for the insurance plan.
Procedure/Payment/Adjustment Window, General Tab	Purchase Service Amount	Use this field to enter amounts you pay a lab or other vendor for technical services they performed for you for the procedure, such as lab testing. This amount will appear on the Transaction Entry window and a summary total of these amounts on the Claim window.
Procedure/Payment/Adjustment Window, General Tab	NDC Unit Price	Use this field to enter the unit price of a drug or biologic.
Transaction Details	Reference ID Qualifier	Use this field to specify a qualifier for the Rx#/Reference ID.
Procedure/Payment/Adjustment Window, General Tab	NDC Unit of Measurement	Use this field to enter the unit of measurement that is used for the drug or biologic.

Menu Changes

The option for UB-04 Condition Codes has moved from the UB04 Code Lists menu to the main Lists menu.

Additional Options

- **Additional Diagnosis Codes:** The program now allows you to have up to 12 diagnosis codes for a case. The following fields and windows are affected:
 - **Program Options, Data Entry tab:** Number of Diagnosis can now be set from 4-12.
 - **Transaction Entry:** You can now have columns for up to 12 diagnosis codes, as well as up to 12 column check boxes to specify if the code is being used for that procedure.

- **Unprocessed Transactions:** You can now have up to 12 columns for diagnosis codes on the List window, as well as the Edit window.
- **Case Window, Diagnosis Tab:** You can now have up to 12 Default Diagnosis fields.
- **Patient/Guarantor, Name, Address Tab, Sex field:** Added the option Unknown
- **Case Policy 1, 2, and 3 tabs:** Relationship to Insured has several new options.

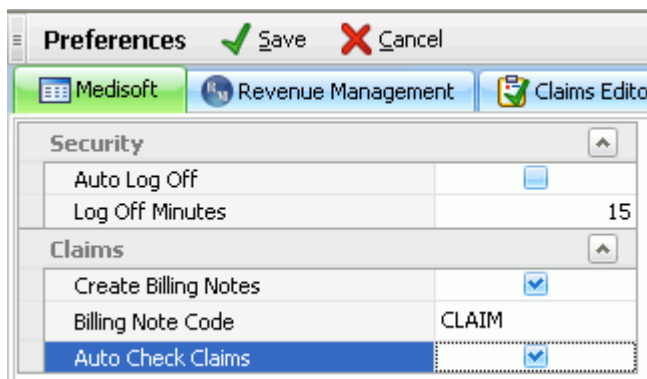
Other Changes

- **Medicaid Referral Access # field** is now called Referral Access #.
- **Case Window, Condition Tab:** First Consultation Date field is now called Initial Treatment Date.
- **Case Window, EDI Tab:** Timely Filing Indicator field is now a drop-down instead of a free-form text field.
- **Case Window, EDI Tab:** The EPSDT Referral Code field is now a drop-down.
- **Insurance Type Code:** Removed this field from the EDI tab on the Case window.
- **Claim Filing Indicator Code:** Added four new items to the drop-down:
 - Dental Maintenance Organization
 - Federal Employees Program
 - Other Federal Program
 - Commercial Insurance Co
- **Relationship to Insured:** items in the list have been rearranged so that values valid for 5010 are on top and legacy values for 4010 are on the bottom.
- **Timely Filing Indicator:** This is now a drop-down with preset values, to ensure that a valid value is always selected.

Revenue Management Click Reduction

Several changes have been made to the functionality and workflow of Revenue Management to reduce the number of times that the user must click to achieve the desired result. Among these changes are:

- Claims will be auto-checked so that the user does not need to click Check Claims. There is a new option on the Medisoft tab in Revenue Management Preferences called **Auto Check Claims**. Selecting this option will enable the program to auto check the claims when the user selects **Process > Claims**.



- Claim edit checks and IG edit checks have been combined into one step and executed when you select Claims from the Process menu. Errors are displayed on the Claims Preview report, as well as under each individual claim.
- One click removal of all claims marked with a red X, eliminating the need to click Remove Claim many times. An icon  appears next to the Remove Claim button on the Claim Preview window. Clicking this icon will remove all claims marked with a red X.
- Addition of a Failed Claim report that will be displayed when the Send button is selected from the Claim Preview window. This report will display all claims that were removed, eliminating the need to preview this report separately.
- Claims that fail any edit and are removed from the transmission file will be written back to Medisoft and the status in Medisoft changed to Alert. Denial information will be written to the History tab in Revenue Management and the Comments tab on the Claim window in Medisoft.
- Remove the OK button displayed after clicking Send from the Claim file saved message. Remove the Transmission has been received button that displayed after the file was sent/received.

Revenue Management 5010 ERA Changes

Changes have been made to Revenue Management processing to handle the upcoming switch to 5010 ANSI. Among these are the following:

- Updates to the 5010 RelayHealth IG. These updates include:
 - For the 835 IG, the **TRN02** element has increased size to a maximum of 50 characters.
 - The **N407** element (Country Subdivision Code) in Loop 1000A AND Loop 1000B has been added to the 835 IG. It is situational and has a maximum length of 3 characters. It is required when the address is not in the United States of America, including its territories, or Canada, and the country in N404 has administrative subdivisions such as but not limited to states, provinces, cantons, etc.
 - Several new elements for Loop 1000A (Payer Identification) in the 835 IG that are not active yet but must be added. In this way, if they are received, the ERA will not be discarded. These are the following:

		POS#	ID	Min/Max	Usage Req	Values
PER	Payer Technical Contact Information	1300		>1	R	
PER01	Contact Function Code		ID	2--2	R	BL
PER02	Payer Technical Contact Name		AN	1--60	S	
PER03	Communication # Qualifier		ID	2--2	S	EM, TE, UR
PER04	Payer Contact		AN	1-256	S	

	Communication #					
PER05	Communication Number Qualifier 2		ID	2--2	S	EM, EX, FX, TE, UR
PER06	Payer Technical Contact Communication #		AN	1--256	S	
PER07	Communication Number Qualifier 3		ID	2--2	S	EM, EX, FX, UR
PER08	Payer Contact Communication #		AN	1--256	S	
PER09	Contact Inquiry Reference		AN	1--20	N/U	
PER	Payer WEB Site	1300		1	S	
PER01	Contact Function Code		ID	2--2	R	
PER02	Name		AN	1--60	N/U	
PER03	Communication # Qualifier		ID	2--2	R	
PER04	Payer Contact Communication #		AN	1-256	R	
PER05	Not Used					

- There are new RDM (Remittance Delivery Method) elements being added to Loop 1000B. These will be ignored in posting but need to be defined in the IG. These are the following:

		POS#	ID	Min/Max	Usage Req	Loop Repeat	Values
RDM	Remittance Delivery Method	1400		1	S		
RDM01	Report Transmission Code		ID	1--2			BM, EM, FT, OL
RDM02	Name		AN	1--60			

RDM03	Communication Number		AN	1--256			
RDM04	Not Used				N/U		

- There is a new DTM (Coverage Expiration Date) element for 5010. This segment explains that coverage was denied because the patient's coverage has expired. The new values are below:

		POS#	ID	Min/Max	Usage Req	Loop Repeat	Values
DTM	Coverage Expiration Date	0500		1	S		
DTM01	Date/Time Qualifier		ID	3--3	R		050
DTM02	Date*		DT	8--8	R		CCYYMMDD
DTM03					N/U		

*This is the date on which the patient's coverage expired.

- There are new Claim Received Date Elements (DTM) in Loop 2100. These have been added to the IG so that they are recognized if they are received. They are not used in posting a remit, however. Here are the new values:

		POS#	ID	Min/Max	Usage Req	Loop Repeat	Values
DTM	Claim Received Date	0500		1	S		
DTM01	Date/Time Qualifier		ID	3--3	R		050
DTM02	Date*		DT	8--8	R		CCYYMMDD
DTM03					N/U		

*This is the date that the claim was received by the payer.

- The number of repeats for the REF Service Identification Element in Loop 2110 has been increased to 8 for 5010. The 4010 required only 7.
- There is a new element for 5010 added to the IG in Loop 2110 (Service Payment Information): REF Healthcare Policy Identification. Here is a table of the values:

		POS #	ID	Min/Max	Usage Req	Loop Repeat	Values
REF	HealthCare Policy Identification	1000		5	S		
REF01	Reference Identification Qualifier		ED	2--3	R		OK
REF02	Healthcare		AN	1--50	R		

	Policy Identification						
--	-----------------------	--	--	--	--	--	--

- Updates to reports:
 - **Claim Preview Report** now includes:
 - any suffix after the patient's name (Segment NM107 in Loop 2100).
 - the Coverage Expiration Date for an expired policy (DTM Coverage Expiration Date in Loop 2100).
 - the Claim Received Date, which shows the date the claim was received by the payer (DTM Claim Received Date in Loop 2100).
 - **Claim Details Report** now includes:
 - any suffix after the patient's name (Segment NM107 in Loop 2100).
 - the Claim Received Date, which shows the date the claim was received by the payer (DTM Claim Received Date in Loop 2100).
 - the specific amounts of a claim (REF Healthcare Policy Identification in Loop 2110).
- Remittance posting includes Coverage Expiration Date in Loop 2100.
- 25 Changes to the 5010 Eligibility IG.

Element	Location	Modification
ISA11 (Interchange Control Standards ID)	Interchange Control Header	Was previously hardcoded to U, but is now blank.
ISA12 (Interchange Control Version Number)	Interchange Control Header	Replaced 00401 with 00501 for use with 5010.
GS08 (Version/Release/Industry Identifier Code)	Function Group Header	Updated from 004010X092 to 005010X279
ST03 (Implementation Convention Reference)	Transaction Set Header	This is a new segment added after ST02 and hardcoded to 00510X279.
NM112 (Name Last or Organization Name)	Loop 2100A	This is a new element for 5010.
NM112 (Name Last or Organization Name)	Loop 2100B	This is a new element for 5010.
REF04 (Reference Identifier)	Loop 2100B	This is a new element for 5010
NM107 (Name Suffix)	Loop 2100C	The insured person's name Suffix has been made available as a data element.
NM112 (Name Last or Organization Name)	Loop 2100C	This is a new element for 5010.
REF04 (Reference Identifier)	Loop 2100C	This is a new element for

		5010.
N407 (Country Subdivision Code)	Loop 2100C	This is a new element for 5010.
DMG10 (Code List Qualifier Code)	Loop 2100C	This is a new element for 5010.
DMG11 (Industry Code)	Loop 2100C	This is a new element for 5010.
DTP01 (Date/Time Qualifier)	Loop 2100C	This has changed from 472 to 291.
EQ01 (Service Type Code)	Loop 2110C	New codes have been added. In addition, there is a new data element that takes the value from the appointment. If that value is null, it takes the value from practice preferences. If that value is null, 30 (Health Benefit Plan Coverage) is hardcoded. The latter is current functionality.
NM107 (Name Suffix)	Loop 2100D	The patient name suffix is added.
NM112 (Name Last or Organization Name)	Loop 2100D	This is a new element for 5010.
REF04 (Reference Identifier)	Loop 2100D	This is a new element for 5010.
N407 (Country Subdivision Code)	Loop 2100D	This is a new element for 5010.
DMG10 (Code List Qualifier Code)	Loop 2100D	This is a new element for 5010.
DMG11 (Industry Code)	Loop 2100D	This is a new element for 5010.
EQ01 (Service Type Code)	Loop 2110D	New codes have been added. In addition, there is a new data element that takes the value from the appointment. If that value is null, it takes the value from practice preferences. If that value is null, 30 (Health Benefit Plan Coverage) is hardcoded. The latter is current functionality.
REF04 (Reference Identifier)	Loop 2110D	This is a new element in 5010.

- The following PER segments have been deleted from Loop 2100B:

		ID	Min/Max	Usage Req	Values

PER	Information Receiver Contact Information		3	S	
PER01	Contact Function Code	ID	2--2	R	IC
PER02	Name	AN	1--60	S	
PER03	Communication Number Qualifier	ID	2--2	S	ED, EM, FX, TE
PER04	Communication Number	AN	1--80	S	
PER05	Communication Number Qualifier	ID	2--2	S	ED, EM, EX, FX, TE
PER06	Communication Number	AN	1--80	S	AAABBBCCCC
PER07	Communication Number Qualifier	ID	2--2	S	ED, EM, EX, FX, TE
PER08	Communication Number	AN	1--80	S	AAABBBCCCC
PER09	Contact Inquiry Reference	AN	1--20	N/U	

Revenue Management Configuration and Setup Changes

Several changes have been made to Revenue Management to simplify the setup and configuration process. Among them are the following:

- Eliminated the Alias table for ERA processing. The user will not need to choose the practice or payor information for ERA processing. Instead, information from the ERA file itself is used to process the ERA file. The Pay To field from Loop 1000B (practice or provider) and the Payer Name field from Loop 1000A Segment N102 (payer information) directly match the information sent out on the claim and will be used, eliminating these steps.
- Allowing the user to edit the Receiver table directly, bypassing the wizard. Certain sections of the table remain locked, however.
- Allow the user to log in to Revenue Management automatically from Medisoft.
- Simplify the setup of ERA. Assign Posting codes will be populated by default with the appropriate payment codes that reference carrier-specific codes in Medisoft. In addition, there is a set of default ERA posting defaults in the **Remit Posting Code** window in Revenue Management. If Use Insurance Posting Codes is checked and there are no carrier-specific codes, these new Default Posting Codes will be sent.

Report Settings | Archive Options | **Remit Posting Options**

☒ Use Insurance Posting Codes ☒ Always Match Last Name

☐ Allow Remittance Edits ☐ Match by Full Name and ID

☐ Change Negative Payments to: [dropdown] ☐ Set Primary Denied Claim to: [dropdown]

☐ Post Secondary Adjustments ☐ Set Secondary Denied Claim to: [dropdown]

☐ Never Write Off Patient Responsible (PR) ☒ Post ICN [CLP07] to Claim Comment

Default Posting Code

Adjustment: [dropdown]

Withhold: [dropdown]

Deductible: [dropdown]

Take Back: [dropdown]

Office Hours Professional Registration

Office Hours Professional is registered at the same time as Medisoft. Although there is still a place where you can register Office Hours Professional, you do not have to perform a separate registration once you register your Medisoft product. Any messages you might receive to register Office Hours Professional can be ignored once Medisoft is registered.

Medisoft Overview

The following topics and links to topics discuss key elements such as new features, data conversion, accessing and step-by-step procedures, along with offering a brief description of key windows/features and links to these features.

Step-By-Step Procedures

There are a series of step-by-step procedures in the Help file that give instructions on using Medisoft. Open the Contents tab of the help file and click the Step-By-Step Procedures book to see all the areas in the program for which these procedures are available.

Navigating in Medisoft

Once the program is open, you can get a good look at the main program window.

Title Bar

The top bar on the window is the Title bar and it displays the name of the active program and contains Minimize, Maximize, and Close buttons on the right side.



Menu Bar

Just below the Title bar is the Menu bar, which shows categories of activities available in the program. Click the various headings, such as File, Edit, Activities, Lists, Reports, Tools, Window, and Help, and each opens a submenu with a list of all the activity options available in that category.



Toolbar

Below the menu bar is the toolbar with an assortment of speed buttons (or icons) that are shortcuts to accessing options within the program.

Select the option you want by clicking the appropriate button.

The toolbar can be customized to fit your organization's needs. Change the order of the buttons in the toolbar or remove them so they do not appear. Create a new toolbar with only the buttons or file names that you want. In addition, you can move the toolbar to the top, bottom, or either side of the screen or return it to its original position and layout.

F1 Look up Toolbar Customizing.



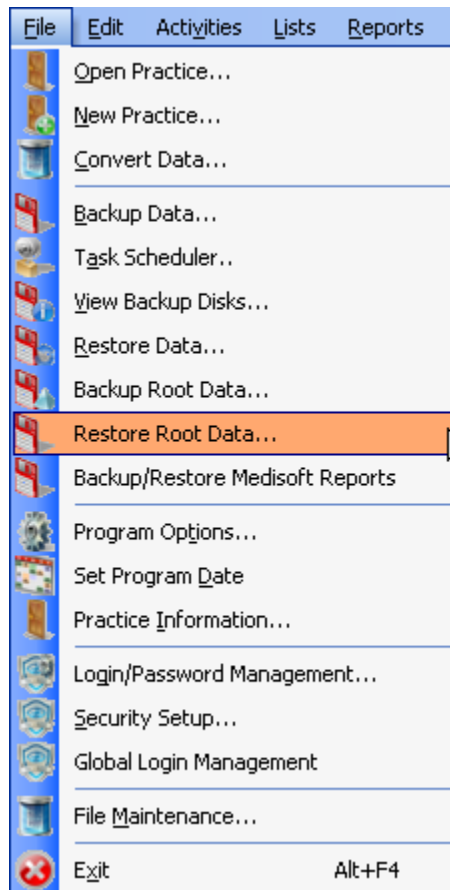
Button	Definition
	The Transaction Entry icon opens the Transaction Entry window where most of the transactions for the practice are maintained.
	The Claim Management icon opens the Claim Management window where claims are prepared, edited, and sent for payment.
	The Statement Management icon opens the Statement Management window where statements are prepared, edited, and sent for payment.
	The Collection List icon opens the Collection List window where you manage collection items.
	The Add Collection List Item icon opens the Add Collection List Items, which you can use to create collection items.
	The Appointment Book icon opens the Office Hours Patient Appointment Scheduler where appointments for the practice are scheduled.
	The Eligibility icon opens the Eligibility Verification Results window where you can check patient insurance eligibility.
	The Patient Quick Entry icon opens the Patient Quick Entry window. This feature provides another method for creating patient and case records. For more information on this feature, see the topic Patient Quick Entry Overview.
	The Patient List icon opens the Patient List window and access to patient case information.
	The Insurance Carrier List icon opens the Insurance Carrier List window and access to carrier information.
	The Procedure Codes List icon opens the Procedure/Payment/Adjustment List window.
	The Diagnosis Codes List icon opens the Diagnosis List window.

	The Provider List icon opens the Provider List window.
	The Referring Provider List icon opens the Referring Provider List window.
	The Address List icon opens the Address List window.
	The Patient Recall Entry icon opens the Patient Recall: (new) window.
	Clicking the Custom Report List icon displays the Open Report window and lets you print any of the documents listed, such as Statements, Walkout Receipts, Patient Lists, CMS-1500, Superbills, etc. See Custom Report List.
	The Quick Ledger icon opens the Quick Ledger. You can access the ledger by clicking this icon or pressing F7 at almost any time the program is open. If you have already selected a chart number, the Quick Ledger defaults to that chart number.
	The Quick Balance icon opens the Quick Balance window, which displays a selected guarantor's remainder balance.
	The Enter Deposits and Apply Payments icon opens the Deposit List window where you can create and print deposit lists and apply payments to patient transactions.
	The Show/Hide Hints icon is a toggle on/off icon. A Hint is a context-sensitive help feature that displays a short description of that portion of the program or window on which the pointer is resting. A written description of the function is also displayed in the Status bar at the bottom of the window.
	The Help icon opens the Help files.
	The Launch Work Administrator icon opens the Work Administrator program where you can create tasks for users and/user groups.
	Launches the Medisoft Reports Engine (for Medisoft Advanced and Medisoft Network Professional only). Complete all reporting tasks in this window. The Medisoft Report window offers several key features not available when running reports off the Reports menu including new reports and features to enhance productivity. For more information, see the Medisoft Reports overview topic.

	The Edit Patient Notes in Final Draft icon opens the Final Draft program. It is a word processing program that is integrated with your patient accounting program and can be used for creating letters, notices, notes, etc., using data already stored in the patient accounting database.
	Clicking Exit takes you out of the program entirely. If you have the Remind to Backup on Program Exit option activated in Program Options, you are reminded to back up your files before the program is shut down.

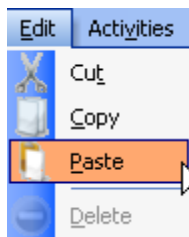
File Menu

The File menu contains options for managing your practice files.



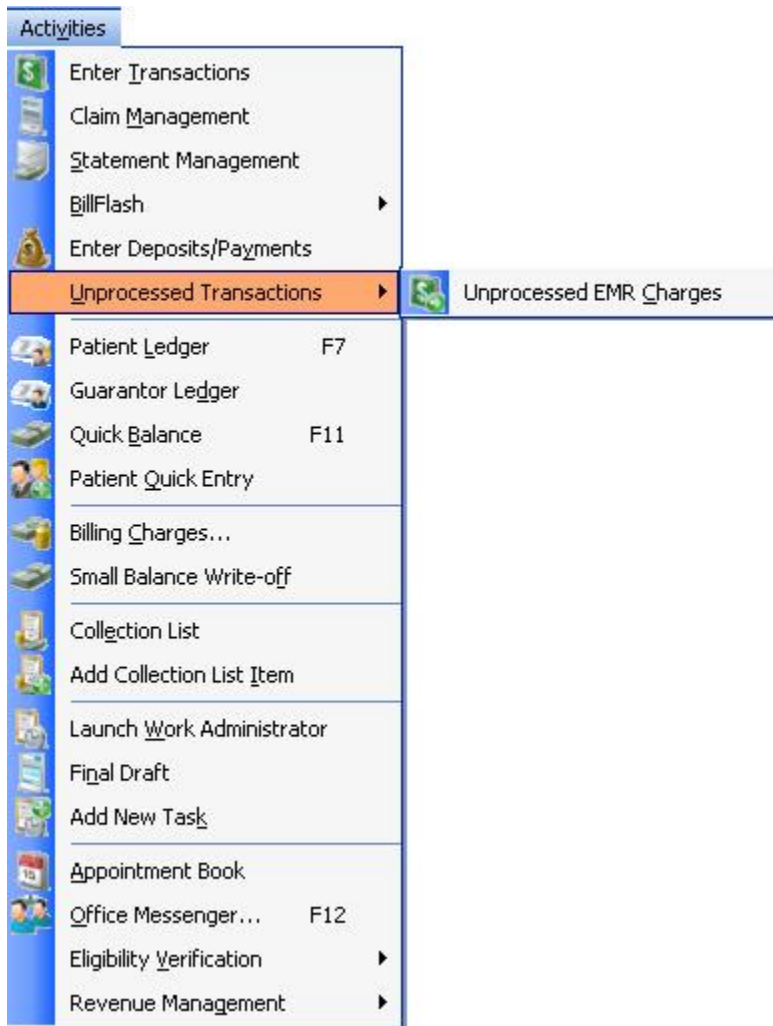
Edit Menu

The functions of the Edit menu are Cut, Copy, Paste, and Delete. These deal primarily with the handling of text.



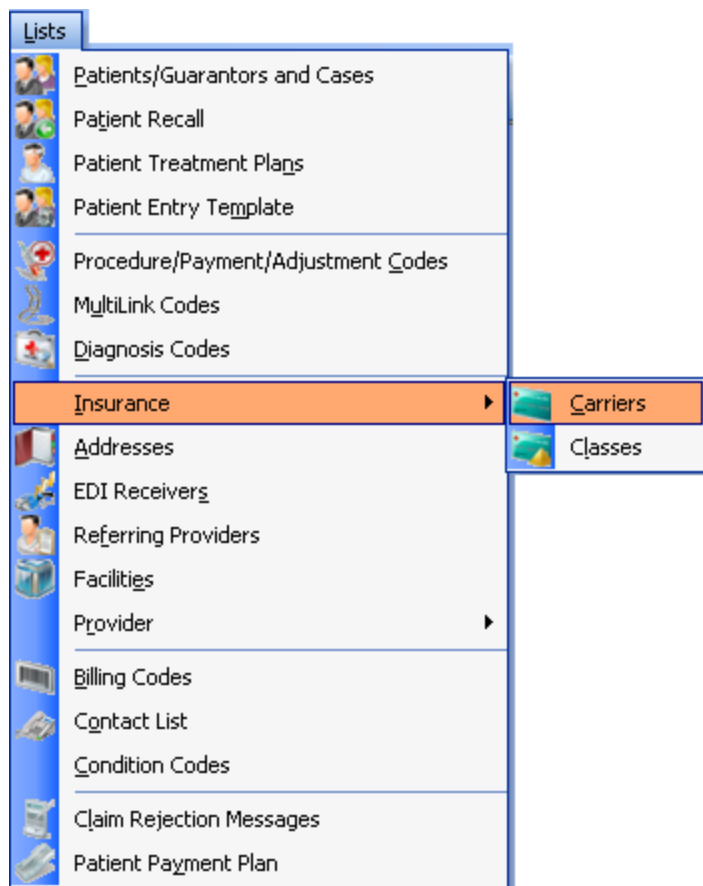
Activities Menu

This is the center of much of the daily routine of the practice.



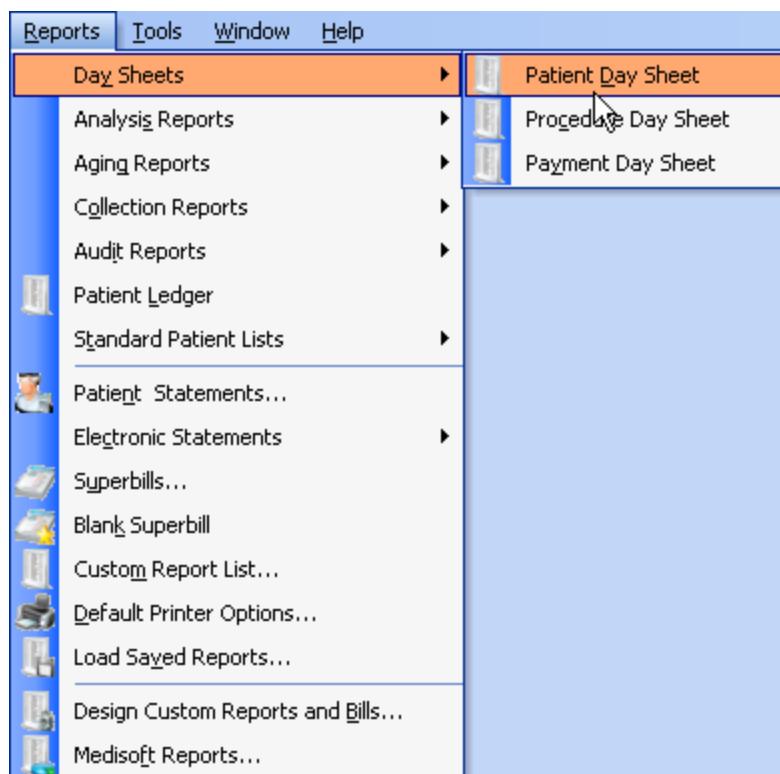
Lists Menu

This menu provides access to the various list windows available in the program.



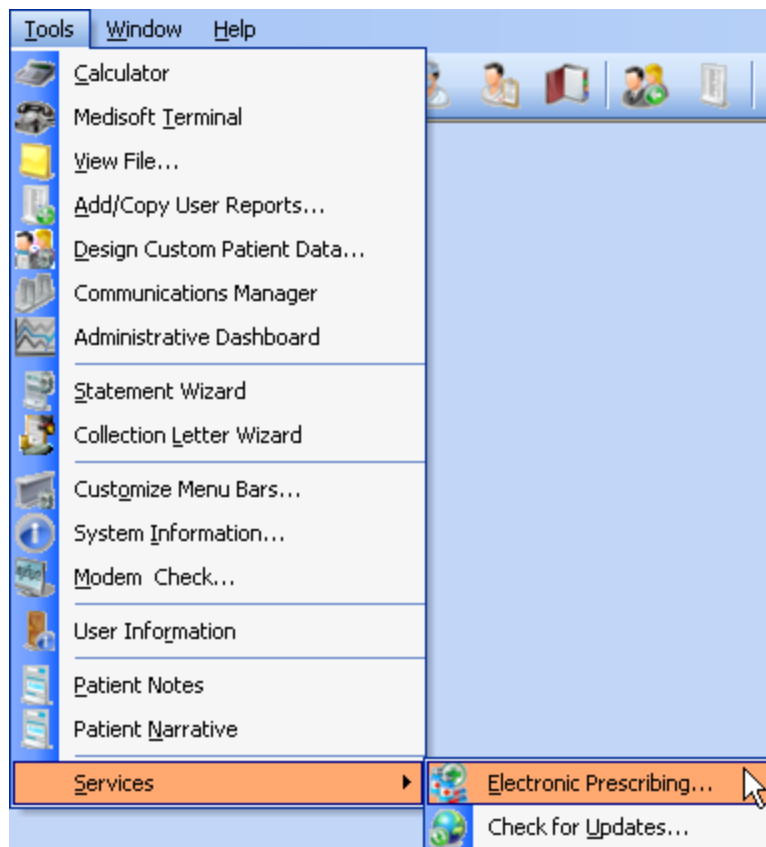
Reports Menu

Reports within Medisoft are accessible through the Reports menu. You can also access the Custom Report List and the Report Designer through this menu.



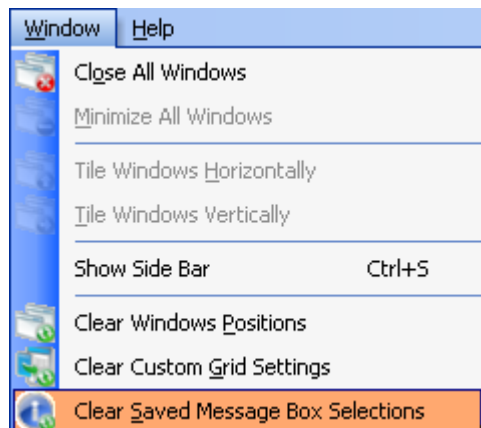
Tools Menu

The options available in this menu help you access peripheral programs and information to assist in the management of your practice.



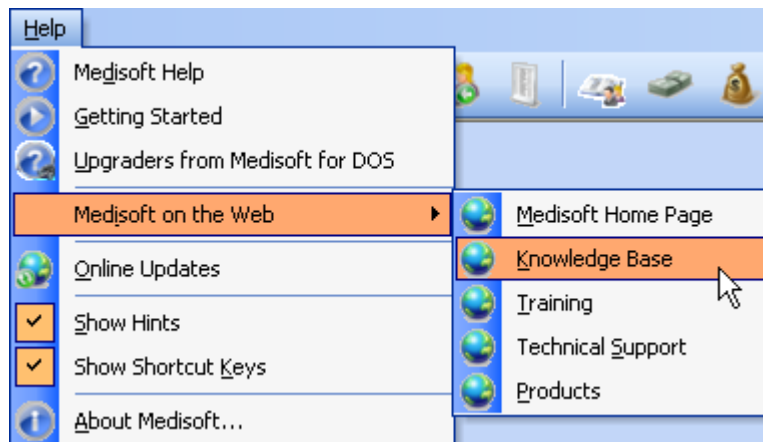
Window Menu

This menu contains options that control the display of windows in the program.



Help Menu

The Help menu contains access to information on how to use the program, as well as how to register.



Shortcut Bar

At the bottom of the screen, above the Status bar, is a shortcut bar that describes the available shortcut function keys available in the active window. This bar may also be referred to as the “function help bar.”



Medisoft at a Glance

Setting up Your Practice

The Provider window contains important information about the providers associated with your practice.

Provider: (new)

Address | Reference | Provider IDs

Code: If the Code is left blank, the program will assign one. ☐ Inactive

Last Name:

First Name:

Middle Name: Credentials:

Street:

City: State: Zip Code:

E-Mail:

Office: Fax:

Home: Cell:

☐ Signature On File Signature Date:

☐ Medicare Participating License Number:

Save Cancel Help Set Default

Each provider in the practice needs to have his or her own record set up in the database. You can use the Provider Class window to enter classes or groups for providers.

Provider Class: (new)

Class ID:

Class Name:

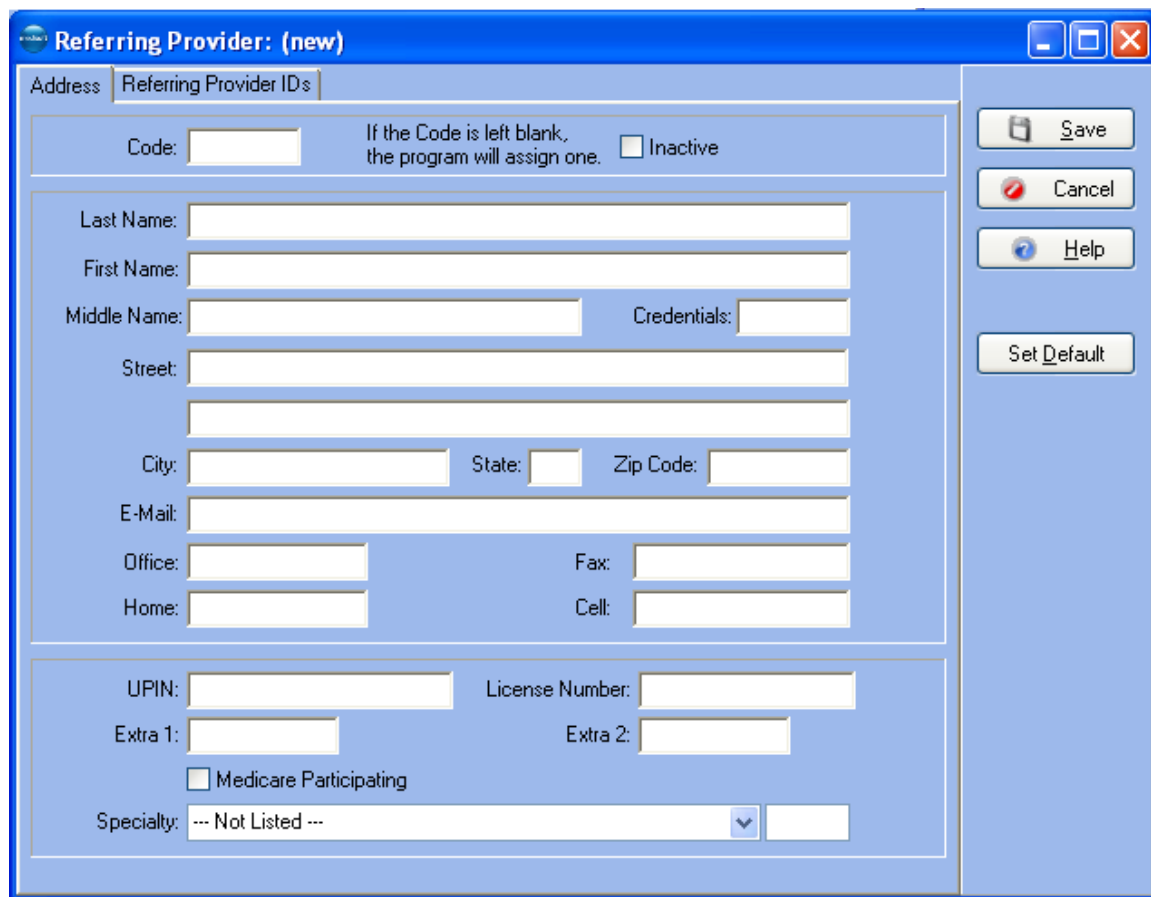
Description:

Inactive ☐

Save Cancel Help

Classes can be used when assigning rules. For more information on assigning rules, see the topic Assigning Rules.

The Referring Provider window contains important information about the referring providers associated with your practice.



Referring Provider: (new)

Address | Referring Provider IDs

Code: If the Code is left blank, the program will assign one. ☐ Inactive

Last Name:

First Name:

Middle Name: Credentials:

Street:

City: State: Zip Code:

E-Mail:

Office: Fax:

Home: Cell:

UPIN: License Number:

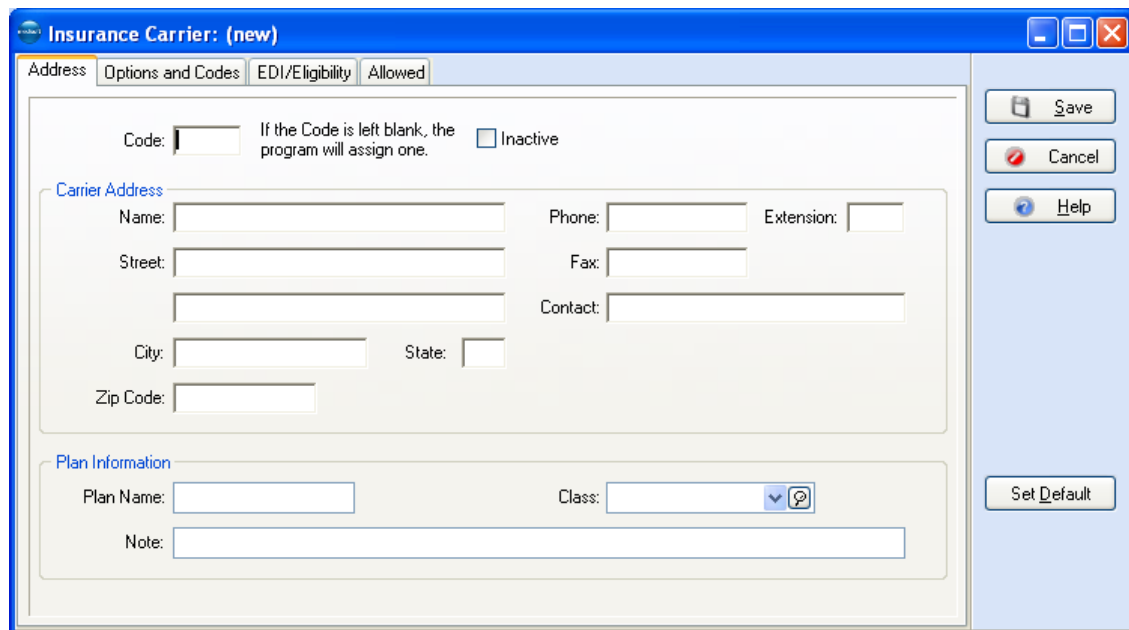
Extra 1: Extra 2:

☐ Medicare Participating

Specialty: --- Not Listed ---

Save Cancel Help Set Default

You will use the Insurance Carrier window to enter insurance carrier records.



Insurance Carrier: (new)

Address | Options and Codes | EDI/Eligibility | Allowed

Code: If the Code is left blank, the program will assign one. ☐ Inactive

Carrier Address

Name: Phone: Extension:

Street: Fax:

City: State: Contact:

Zip Code:

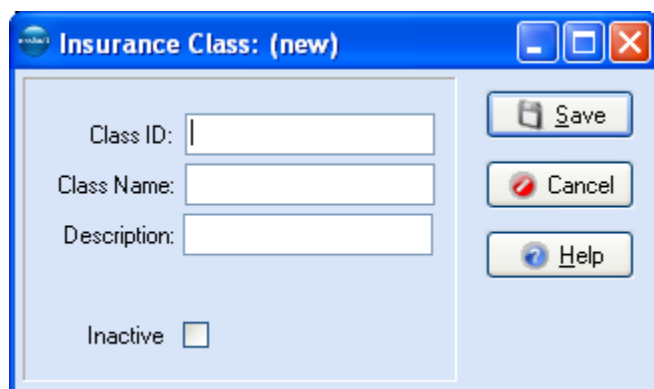
Plan Information

Plan Name: Class:

Note:

Save Cancel Help Set Default

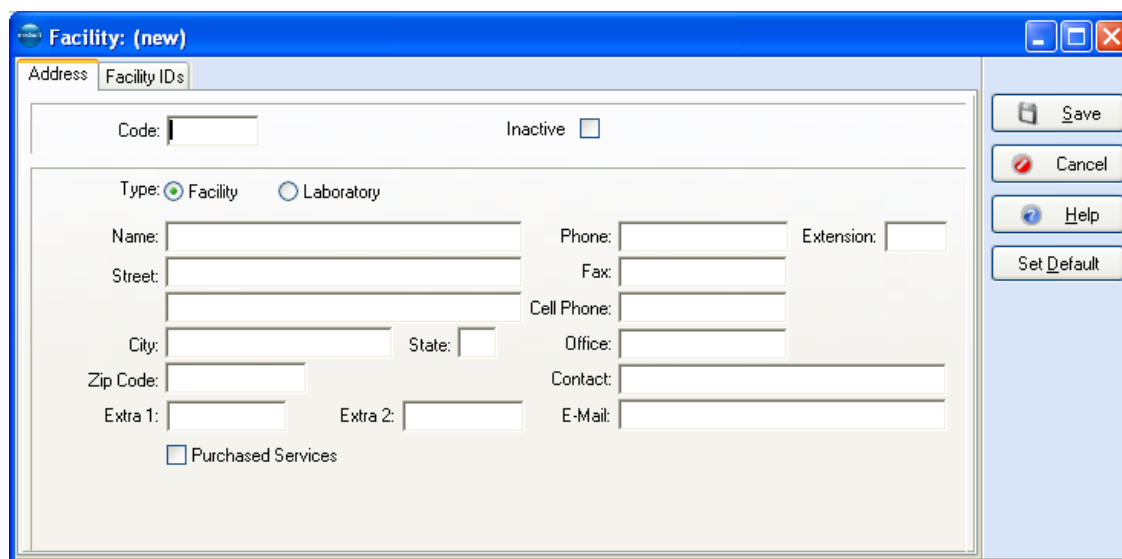
You will use the Insurance Class window to enter classes or groups for insurance carriers.



The "Insurance Class: (new)" dialog box is a standard Windows-style window with a blue title bar. It contains three text input fields on the left: "Class ID:", "Class Name:", and "Description:". Below these fields is an "Inactive" checkbox. On the right side of the dialog, there are three buttons: "Save" (with a floppy disk icon), "Cancel" (with a red X icon), and "Help" (with a question mark icon).

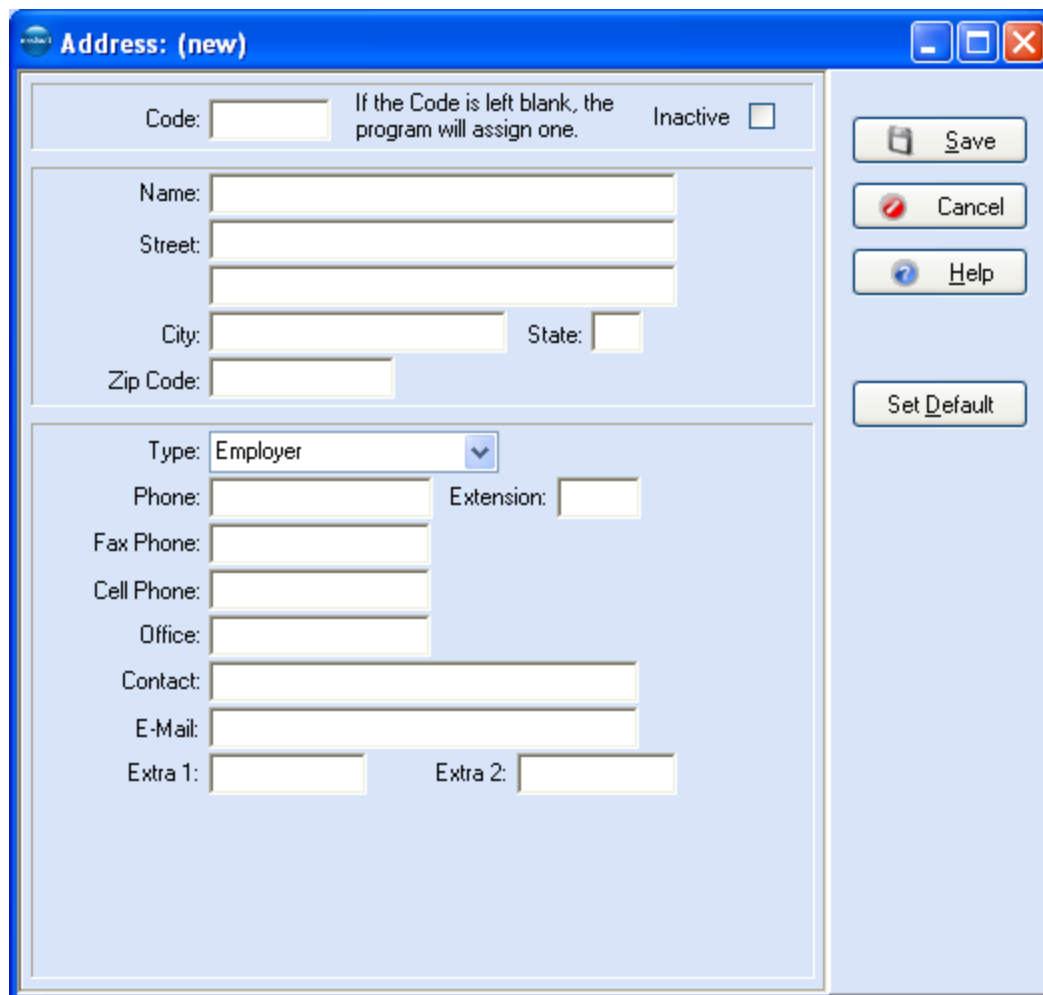
Classes can be used when assigning rules. For more information on assigning rules, see the topic Assigning Rules.

The Facility window contains important information about the labs and facilities associated with your practice.



The "Facility: (new)" dialog box has a blue title bar and two tabs at the top: "Address" and "Facility IDs". The "Address" tab is currently selected. The main area contains several input fields: "Code:" and "Inactive" checkbox at the top; "Type:" with radio buttons for "Facility" (selected) and "Laboratory"; "Name:", "Phone:", and "Extension:"; "Street:", "Fax:", and "Cell Phone:"; "City:", "State:", and "Office:"; "Zip Code:", "Contact:", and "E-Mail:"; and "Extra 1:" and "Extra 2:". At the bottom left is a "Purchased Services" checkbox. On the right side, there are four buttons: "Save", "Cancel", "Help", and "Set Default".

The Addresses window is used to enter address information important to your practice.



Address: (new)

Code: If the Code is left blank, the program will assign one. Inactive ☐

Name:

Street:

City: State:

Zip Code:

Type:

Phone: Extension:

Fax Phone:

Cell Phone:

Office:

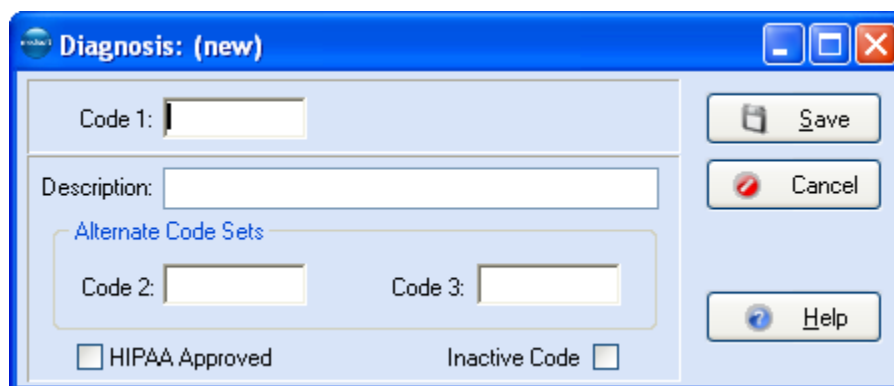
Contact:

E-Mail:

Extra 1: Extra 2:

Buttons: Save, Cancel, Help, Set Default

The Diagnosis List window displays all diagnosis codes that have been entered into the database and controls to edit or enter new codes.



Diagnosis: (new)

Code 1:

Description:

Alternate Code Sets

Code 2: Code 3:

☐ HIPAA Approved ☐ Inactive Code

Buttons: Save, Cancel, Help

You will use the Procedure/Payment/Adjustment Code window to enter and edit, etc. procedure codes.

Procedure/Payment/Adjustment: (new)

General | Amounts | Allowed Amounts

Code 1: ☐ Inactive

Description:

Code Type:

Account Code:

Type of Service:

Place of Service:

Time To Do Procedure:

Service Classification:

Don't Bill To Insurance:

Only Bill To Insurance:

Default Modifiers:

Revenue Code:

Default Units:

National Drug Code:

Code ID Qualifier:

☐ Taxable ☐ Patient Only Responsible

☐ HIPAA Approved ☐ Purchased Service

☐ Require Co-pay

☐ HCPCS Code

HCPCS Rate Code:

Alternate Codes

2:

3:

Save Cancel Help

If you process electronic claims, you can use the EDI Receivers window to initially create EDI receivers. EDI Receivers are also set up in the Revenue Management feature.

The Patient List window is the main space for entering/editing patient and case information. Another method for entering/editing patient and case information when using Medisoft Advanced and Network Professional, is the Patient Quick Entry window.

You can also take advantage of Medisoft's security features and set up different users with varying degrees of permissions to application functions.

Scheduling Appointments

Scheduling appointments is simple using Medisoft's integrated appointment scheduling application, Office Hours.

Entering Transactions and Payments

You enter charges via the Transaction Entry window and you can also apply payments using this feature. Users of Medisoft Advanced or Network Professional can take advantage of the Deposit List window for entering payments.

Generating Claims and Statements

Claims processing centers on the Claim Management window from which you can create, edit, and print/send claims. Medisoft also provides support for UB-04 claims. And you can use the Statement Management window (available in Medisoft Advanced or Network Professional) to create billing statements for patients. For more information, see Medisoft Claim Generation FAQ and Electronic Claims Overview.

Running Reports

You can use the robust reporting capabilities of Medisoft to keep track of your office's performance. Medisoft offers a rich list of reports to manage office functions and analyze your practice's performance.

Running Utilities

Medisoft also provides easy automation of several functions via the Task Scheduler and EMR interfacing via the Communications Manager. Medisoft Advanced and Network Professional users can also take advantage of the Dashboard, a utility that monitors and displays key functions of the practice.

Keystrokes and Shortcuts

Special keyboard shortcuts reduce the number of times you have to click the mouse or press keys to accomplish a task.

Keystrokes Common to Most of the Program

Keystroke	Action
F1	Opens Help files in most windows
ESC	Closes or cancels current function or window
F3	Saves
F6	Opens a search window
F7	Opens the Quick Ledger window
F8	Opens a window to create a new record
F9	Opens a window to edit the selected record
F11	Opens the Quick Balance window
F12	Opens Medisoft Office Messenger
SPACEBAR	Toggles check box (check/uncheck)
ENTER	Depends on settings in the Program Options window
CTRL + S	Toggles Sidebar display
CTRL + X	Cuts selected text
CTRL + C	Copies selected text
CTRL + V	Pastes selected text
ALT + DOWN ARROW	Opens drop-down lists
SHIFT + F4	This shortcut automatically populates the last accessed patient's

chart in a new chart number field. The system holds in memory the last patient's chart number selected (for instance in the Patient List, Deposit List, Collection List, Quick Ledger, Quick Balance, etc.), and when you go to another window, you can use the shortcut to populate the last record. Select the Chart field and press SHIFT + F4 to automatically populate the last accessed patient's chart in a new chart number field. This feature is supported in many windows throughout the system.

NOTE: Reports that do not use the Data Selection Questions window for data filtering, do not support this feature.

Keystrokes-Formatted Date Edit Controls

Keystroke	Action
+	Increases date by one day (or highlighted section of date by one)
-	Decreases date by one day (or highlighted section of date by one)

Keystrokes-Grid Control in Various Windows

Keystroke	Action
LEFT ARROW	Moves left one cell
RIGHT ARROW	When not in edit mode, moves right one cell
CTRL + RIGHT ARROW	When in edit mode, moves right one cell
UP ARROW	Moves up one cell
DOWN ARROW	Moves down one cell
PAGE UP	Moves up one page
PAGE DOWN	Moves down one page
ENTER	Moves to the next cell

Keystrokes-List Windows

Keystroke	Action
F2	Changes value in Field
F3	Saves record
F8	Creates new record
F9	Edits selected record

Keystrokes-Transaction Entry

Keystroke	Action
F2	Opens the MultiLink window
F4	Opens Apply Payment to Charges window
F5	Opens Transaction Documentation window

Keystrokes-Eligibility

Keystroke	Action
F10	Opens the Eligibility Verification Results window when Eligibility is enabled.

Keystrokes-Report Designer

Keystroke	Action
CTRL + F	Opens the Find Dialog for searching
CTRL + O	Opens the Open Report window to print a report
CTRL + S	Save As
CTRL + F4	Closes the open report
ALT + F4	Exits Report Designer
LEFT ARROW	Moves selected components left
RIGHT ARROW	Moves selected components right
UP ARROW	Moves selected components up
DOWN ARROW	Moves selected components down
CTRL + F	Find field
CTRL + A	Find again
CTRL + X	Cuts selected text
CTRL + C	Copies selected text
CTRL + V	Pastes selected text

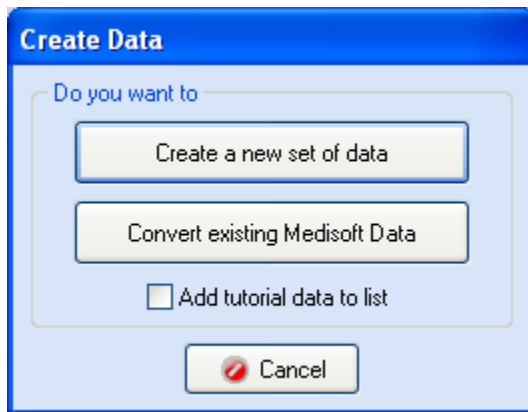
Setting up the Program and Setting up the Practice

Setting up the Program

Before you can use the Medisoft program, you have to create a practice. You might only need to create one practice, but you can create multiple practices if necessary.

Creating a Practice

When you first open the Medisoft program after installation, you are required to create a new data set (if this is the first time you have ever installed Medisoft) or convert previous Medisoft or MS-DOS data.



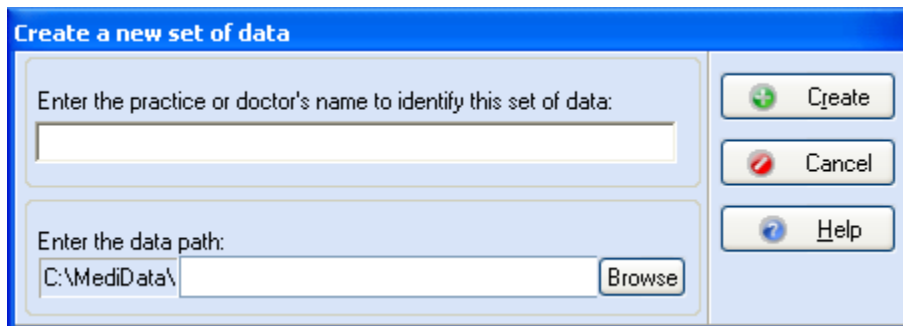
If you have been using Medisoft Version 5.5x or 5.6x and above and have just installed Version 17, a message displays stating that data must be converted before you can access the program. If you have not already performed a backup on your existing data, perform a backup now. Then click **OK** to perform the automatic conversion.

If you work with multiple practices, each will have to be converted.

For more conversion information:

F1 Converting from Windows Version 5.4x or Lower to Medisoft Version.

If you choose to create a new data set, the **Create a New Set of Data** window is displayed. Fill in the practice name and the practice data path. The data path is the location within the MediData folder in which the practice data is stored.



When you click **Create**, the **Practice Information** window appears. On this window on the Practice tab, you will enter your basic practice information such as the name of the practice, address, telephone number.

TIP: When initially setting up your practice, considering entering the practice name only. You can then complete this tab and the other tabs on the window, later in the setup process. Some of the settings on the other tabs, especially the Practice IDs tab, require setup first.

For more information on these settings, see the topics *Entering Practice Information* and *Entering Practice Information for a Billing Service*.

Other Setup Information

Creating Multiple Practices

It is not necessary to install the program for each new practice. To set up multiple practices, go to the **File** menu and select **New Practice**. When the first practice is set up in the Medisoft program, the program assumes there is only one practice and establishes a default directory for the data for that practice. Each time you set up an additional data set with totally unrelated patients and procedure files, you must create a different subdirectory. In the **Create A New Set Of Data** window, enter the additional practice name and change the data path. This establishes a completely separate database for the new practice.

Once you have set up additional practices, you can move easily from one to another by going to the **File** menu, selecting **Open Practice**, and choosing the practice you want from the list presented.

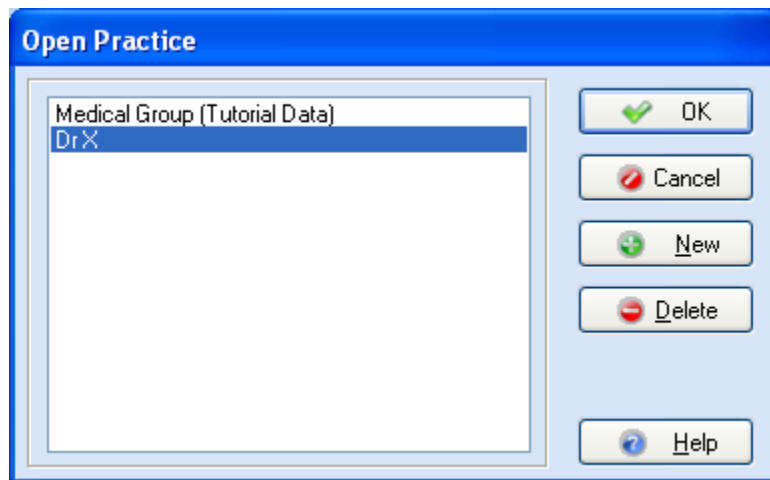
Changing the Program Date

You can change the program date for back dating a large number of transactions. This affects all dates in the program except the Date Created setting, which always reflects the System date.

Opening a Practice

To change practices or create a new practice database, go to the **File** menu and select the appropriate option.

To open an existing database, go to the **File** menu and select **Open Practice**. Choose the practice you want to open and click **OK**.



Setting up the Practice

Setting up the Practice

Once you have the program set up, the next step is to enter data into each of the different areas of the program, i.e., entering insurance carrier records in the Insurance Carrier window, entering procedure codes in the Procedure, Payment, and Adjustment Codes window, and so on. Here is a sequence for practice setup that should help you enter your practice information without moving back and forth between windows. You will set up elements (records) that are referred to in other records and grid entries.

TIP: You can follow a different setup order for many of these activities; the following setup order calls for you to create records that are associated with other records first to avoid having to go back and recreate them. Depending on your office environment and business, you might follow a different setup order (if you have a large number of providers, you might set that up earlier, if you file very few EDI claims, you might set that up later, etc.)

- Set up security
- Set up preferences
- Enter practice information on the Practice Information window, Practice Settings tab
- Set up EDI Receivers
- Enter insurance carrier records
- Enter facility records
- Enter practice information on the Practice Information window, Practice IDs tab
- Enter provider records
- Enter referring provider records
- Enter procedure codes and multilink codes
- Enter diagnosis codes
- Billing Codes
- Enter other address records
- Enter guarantor and patient records

Keeping in mind your practice structure and your filing needs will help you set up your practice. Also consider reviewing the Assigning Rules topic before completing grid entries on the Practice, Provider, Facility, and Referring Provider IDs tabs since these entries or rules determine what information is pulled/included in a print or electronic claim.

Rules Creation and IDs Grid Row Selection

Medisoft claim processing for both print and electronic claims depends on a series of flexible rules that you define on the various ID grids in the application. When setting up or updating your practice data, you will create a series of grid entries (rules) on the Practice IDs and Provider IDs grid. You may also use the Facility IDs and Referring Provider IDs grids depending on your practice structure. The grid entries that you complete contain your basic practice information, such as group or individual NPI, taxonomy, tax IDs, and claim filing status (group or individual), and connect this information to the insurance carriers that your practice accepts and the doctors in your practice as a series of rules.

You begin by creating general entries for each provider on the Provider IDs grid and by creating at least one entry on the Practice IDs grid level.

NOTE: The setup for solo providers offers more flexibility. Also taxonomy requirements or NPI setup considerations can impact how you create your practice. For more information, see:

F1 An Overview of Setting up the Practice.

In these general entries, you enter information that would apply to the most generic situation. Then you would create other grid entries that apply to a specific insurance carrier, insurance class, facility, provider, etc.

TIP: When creating or editing IDs grid entries, do not create matching wild card entries (all selected for insurance carrier and insurance class) since the rules engine would not know which row to select. If you had different legacy numbers (for instance, in each entry), the system might not select the correct row. In this case, modify one of the wild card rows and apply it to a specific insurance carrier or class.

When you create claims, the application gathers general data and then selects data from the IDs grids by analyzing the entries (rows) on the various IDs grids. The process of selecting the correct row involves first selecting a row that applies to the insurance carrier, provider, or provider class. If more than one row is present on the various ID grids, the application matches the row on an IDs grid to the data gathered for the claim. The logic looks for a specific match on an IDs grid first before moving to a general match (All button); for instance, the application searches for insurance carrier X before looking for a row that applies to all insurance carriers.

The logic continues matching the other various selections on the grids. For instance, if one or more entries are on the grid, the application would see which entries match the facility on the claim. This pattern has a specific order and follows the left to right layout on the IDs grid. For instance, on the Practice IDs grid, the logic looks at provider code first, then insurance carrier, then facility, etc.

For instance if you are setting up a group practice with three doctors, you would need to have at least one rule (grid entry) on the Practice IDs grid and one rule on the Providers IDs grid for each provider (three rules). You must include an entry for each provider on the Provider IDs grid since you define your claim filing status (individual or group) here. For this general rule on the Practice IDs grid, you could apply it to all providers, all insurance carriers, and all facilities (assuming you have no facilities associated with your practice or all facilities would use the same details).

In this entry, you could include your group NPI, taxonomy, and tax ID numbers. Then on the Providers ID grid, you would create one grid entry for each provider. Each of these initial entries would be general and could apply to all insurance carriers and facilities. You would also select Group for your claim type and could select From Practice to pull NPI, taxonomy, and Tax IDs from the Practice IDs grid. If one of the insurance carriers that your practice accepts requires a legacy identifier, you would create a second entry on the Practice IDs grid. By creating a second entry on this grid instead of the Provider IDs grid, you save time and effort since one specific entry could be applied to all the providers at the practice level instead of creating an entry for each provider on the provider level. In this second entry, you would select the insurance carrier and select all providers. Importantly, you would need to include your NPI, taxonomy, and Tax IDs since each grid entry needs to be complete. You would also select the legacy number your carrier requires. When the application gathers claim data, it would select this row for the specific insurance carrier and pull the data for the claim.

If one of the providers in your practice files claims as an individual with an insurance carrier the other providers do not use, you would need to create another rule on the Provider IDs grid for that provider. In this grid entry, you would specify the insurance carrier. You would also change your filing status to Individual and enter the provider's NPI number, not the group NPI number. You could also include the taxonomy and tax ID/social security number in this grid entry.

NPI Setup Considerations

Depending on the setup of your practice and your claim submission requirements, you can enter the NPI number on the Practice window, the Practice IDs grid, the Provider window, the Providers IDs grid, or on both windows.

Solo Provider (file claims as an individual)

If you are a solo provider (file claims as an individual) with the same pay to as your billing address (the Pay To tab is blank), you can enter your NPI information on the Practice IDs grid. In this case, you would select on the Providers IDs grid the From Practice button instead of selecting the National Provider ID button and entering an NPI number.

If you are a solo provider with different billing information and pay to information (the Pay To tab is complete), you can enter your NPI information on the Provider IDs grid. In this case, you would select on the Providers IDs grid the National Provider ID button and enter your NPI number. Entering the NPI number on the provider level is required in this case to pull your NPI number in Loop 2010AB. If you left it only on the practice level, the NPI number would not pull for this loop.

If you are a solo provider that has insurance carriers that require mixed NPI numbers (some require individual while some require a group), you would enter your group NPI number on the Practice IDs grid. You would then create an entry on the Provider IDs grid in which you would enter your individual NPI number on the Provider IDs grid and apply it to all insurance carriers, an insurance class, or a carrier (you could create several records if needed to address other issues such as legacy numbers, taxonomy, etc.). For those carriers that require the group NPI, you would create at least one other separate entry on the Providers IDs grid (might need more, depending on other issues such as legacy numbers, taxonomy, etc.) for that carrier or insurance class in which you select the From Practice button instead of selecting the National Provider ID button and entering an NPI number.

Member of a Group (file claims as a group)

If you file claims as a group, you can enter your NPI information on the Practice IDs grid. In this case, you would select on the Providers IDs grid the From Practice button instead of selecting the National Provider ID button and entering an NPI number.

Mixed NPI Numbers

If you have insurance carriers that require mixed NPI numbers (some require individual NPI numbers while some require a group), you would enter your group NPI number on the Practice IDs grid. You would then create entries on the Provider IDs grid in which you would enter your the specific provider's individual NPI number on Provider IDs grid and apply it to a specific insurance carrier or an insurance category (you could create several records if needed to address other issues such as legacy numbers, taxonomy, etc.). For more information, see:

F1 Entering and Editing Provider Information

Claim Filing Setup for Individuals and Groups

You set your claim filing status on the Providers window on the Provider IDs matrix by selecting either the Individual or Group buttons. If you always file claims one way (either as an individual or a group), you can select that button and apply this setting to all insurance carriers set up in the system by selecting the All button (might need to create other entries to address issues with NPI numbers, taxonomy, legacy numbers); if some insurance carriers require you to file as group or individual (opposite of your first entry on the grid), you could create a second entry to address this situation on the Providers ID, in which you select the insurance company and select group.

Assigning Rules

Medisoft claim processing for both print and electronic claims depends on a series of flexible rules that you define on the various ID grids in the application. When setting up or updating your practice data, you will create a series of grid entries (rules) on the Practice IDs and Provider IDs grid. You may also use the Facility IDs and Referring Provider IDs grids depending on your practice structure. These grid entries that you complete contain your basic practice information such group or individual NPI, taxonomy, tax IDs, claim filing status (group or individual) and connect this information to the insurance carriers that your practice accepts and the doctors in your practice as a series of rules.

You begin by creating general entries for each provider on the Provider IDs grid and at least one entry on the Practice IDs grid level.

NOTE: the setup for solo providers offers more flexibility. Also taxonomy requirements or NPI setup considerations can impact how you create your practice.

In these general entries you enter information that would apply to the most generic situation. Then you would create other grid entries that apply to a specific insurance carrier, insurance class, facility, provider etc.

TIP: when creating or editing IDs grid entries, do not create matching wild card entries (all selected for insurance company and insurance class) since the rules engine would not know which row to select. If you had different legacy numbers, for instance in each entry, the system might not select the correct row. In this case, modify one of the wild card rows and apply it to a specific insurance carrier or class.

When you create claims, the application gathers general data and then selects data from the IDs grids by analyzing the entries (rows) on the various IDs grids. The process of selecting the correct row involves first selecting a row that applies to the insurance carrier, provider or provider class. If more than one row is present on the various ID grids, the application matches the row on an IDs grid to the data gathered for the claim. The logic looks for a specific match on an IDs grid first before moving to a general match (All button); for instance the application searches for insurance carrier X before looking for a row that applies to all insurance carriers.

The logic continues matching the other various selections on the grids. For instance, if one or more entries are on the grid, the application would see which entries match the facility on the claim. This pattern has a specific order and follows the left to right layout on the IDs grid. For instance, on the Practice IDs grid, the logic looks at provider code first, then insurance carrier, then facility, etc.

For instance if you are setting up a group practice with three doctors, you would need to have at least one rule (grid entry) on the Practice IDs grid and one rule on the Providers IDs grid for each provider (three rules). You must include an entry for each provider on the Provider IDs grid since you define your claim filing status (individual or group) here. For this general rule on the Practice IDs grid, you could apply it to all providers, all insurance carriers, and all facilities (assuming you have no facilities associated with your practice or all facilities would use the same details).

NOTE: for more information on setting up a facility, see the topic Facility Information.

In this entry, you could include your group NPI, taxonomy, and tax ID numbers. Then on the Providers ID grid, you would create one grid entry for each provider. Each of these initial entries would be general and could apply to all insurance carriers and facilities. You would also select Group for your claim type and could select From Practice to pull NPI, taxonomy and Tax IDs from the Practice IDs grid. If one of the insurance carriers that your practice accepts requires a legacy identifier, you would create a second entry on the Practice IDs grid. By creating a second entry on this grid instead of the Provider IDs grid, you save time and effort since one specific entry could be applied to all the providers at the practice level instead of creating an entry for each provider on the provider level. In this second entry, you would select the insurance carrier and select all providers. Importantly, you would need to include your NPI,

taxonomy, and Tax IDs since each grid entry needs to be complete. You would also select the legacy number your carrier requires. When the application gathers claim data it would select this row for the specific insurance company and pull the data for the claim.

If one of the providers in your practice files claims as an individual with an insurance carrier the other providers do not use, you would need to create another rule on the Provider IDs grid for that provider. In this grid entry, you would specify the insurance carrier. You would also change your filing status to Individual and enter the provider's NPI number, not the group NPI number. You could also include the taxonomy and tax ID/social security number in this grid entry.

Setup Activities After Data Conversion

If you are converting data from an existing Medisoft practice, then you will need to review/select your claim filing status (individual or group) for each provider in your practice.

To select your filing status

1. Click **Lists**, select **Provider**, select **Providers**.
2. On the **Provider List** window, select a provider and click **Edit**.
3. Review the data on the **Address** tab and update as necessary. Click the **Provider IDs** tab.
4. The conversion process will have created at least one entry for the provider.
5. On the **Provider IDs** grid, select the first entry and click **Edit**. The **Edit Provider IDs** window opens.
6. If you file claims as an individual, make sure the **Files Claims As Individual** button is selected.
7. If you file claims as a group, make sure the **Files Claims As Group** button is selected.
8. Click **OK**.

Repeat steps 4-7 for any other entries in the grid. When complete, repeat the steps for any other providers in the practice.

To provide the highest level of data integrity and accuracy, the conversion process for Medisoft 17 provider/practice setup does not delete information while creating grid entries that might still be needed, such as legacy information (Blue Cross provider numbers, Medicare provider numbers, etc.) but converts this data to a grid entry in Medisoft 17. Before filing claims, you will also need to finalize your grid entries making sure to remove unnecessary data such as out-of-date legacy numbers.

This activity is especially important for any data entered on PINs tab in previous versions of Medisoft and also if you used the NPI Only check box on the Insurance Carriers window. Since data was converted instead of deleted to provide a high level of data accuracy in Medisoft 17, you will need to remove out-of-date legacy numbers from the new grid entries.

For instance, if you had an entry in the PINS tab in Medisoft 15 for a Medicare provider number and then at a later date selected the NPI only check box on the Insurance Carrier window for this insurance carrier, this legacy number will be converted in Medisoft 17. Before filing a claim with this carrier, you would need to remove this from the grid entry in Medisoft 17. In this example, you would click Lists, select Provider, and select Providers. On the Provider List window, select the provider. Click the Provider IDs tab. When the data converted, the insurance carrier that had required the Medicare provider number will have a specific row on the Provider IDs grid. Select that row and click Edit. Then in the Legacy Identifier 1 field, select the None button. Click Save. You would repeat this process for any other legacy data that is out-of-date.

You will also need to examine each IDs grid (Practice, Provider, Referring Provider, and Facility) before completing print or electronic claims. This step is critical for success, especially

when converting data, with multiple legacy numbers. For instance, if your practice in Medisoft 15 had a referring provider record that had multiple entries on the PINs tab, Referring Provider window, the conversion process will re-create these entries as separate rows, for instance four entries in Medisoft 15 would translate into four entries on the Referring Provider IDs grid. All of these entries would be generic (wild card) rows without any selection of an insurance carrier. These grid entries, however, need modification since all four would be generic/ wild card rows in which all is selected for insurance carrier.

Before filing claims, you would need to first examine the legacy numbers and see if all are still needed. Then, you would begin adding, deleting, or editing entries to match your claim filing needs. For instance, you might keep the generic/wild card row since this information is needed for most of the insurance carriers you file claims with. Then, you might select one of the other legacy wild card rows (the rows in which All insurance carriers and all insurance classes are selected) and apply this rule to a specific insurance carrier or class. If needed, you could add a second legacy number if the carrier required it. You could delete the other entries or apply an insurance carrier or class to the entry.

If you do not review and modify your ID grid entries, you can potentially have problems when filing claims if you leave multiple wild card rows (all selected for insurance carriers and insurance classes) since the rules engine would not know what rule to select. In this case, the rules engine might select the correct (most complete wild card row) row but could also pull one that contained the wrong legacy id resulting in a claim rejection.

Setting Program Options

The **Program Options** window contains set conditions which affect fields and program operations in different parts of the program. Go to the **File** menu and select **Program Options**. The **Program Options** window opens.

The screenshot shows the 'Program Options' window with the 'General' tab selected. The window has a blue title bar and a standard Windows-style interface. On the right side, there are 'Save', 'Cancel', and 'Help' buttons. The main area is divided into several sections:

- Backup Section:** Includes a checkbox for 'Remind to Backup on Program Exit', a text field for 'Backup Program:' containing 'MBACKUP.EXE', and a 'Command Line:' field. A 'Max Automatic Backup Count:' spinner is set to 3.
- Show Windows on Startup:** Includes checkboxes for 'Patient List' and 'Transaction Entry'. Below this is the 'Data Version Number: 28'.
- Menu/Toolbar Options:** Includes a checkbox for 'Hide Icons in Menus'.
- Calculate Patient and Statement Remainder Balances:** Includes radio buttons for 'when Medisoft first opens', 'when Medisoft closes', and 'None of the above' (which is selected). A note below states: 'Patient Remainder Balances may also be recalculated through File Maintenance.'
- Account Alert Setting:** Includes checkboxes for 'Show Hints', 'Show Shortcuts', 'Enforce Accept Assignment', 'Print Report Title Page', 'Enable Electronic Prescribing', 'Use Server Time', 'Hide Inactive/Closed Items', and 'Use Guarantor Ledger for Quick Ledger'. Below this is a section for 'Account Alert Setting' with checkboxes for 'Patient Remainder Balance', 'Delinquent on Payment Plan', 'Sent to Collections', 'Outstanding Co-payments', and 'All of the above' (which is selected). A text field is next to 'Patient Remainder Balance'.

TIP: During initial setup, for most users the default settings on the various tabs on the window, are sufficient for initial use. You can customize these settings at a later date.

Each tab features settings for different functional elements in the application. For more information on the available options and settings, see:

General Tab

Data Entry Tab

Payment Application Tab

Aging Reports Tab

HIPAA Tab

Color-Coding Tab

Billing Tab

Audit Tab

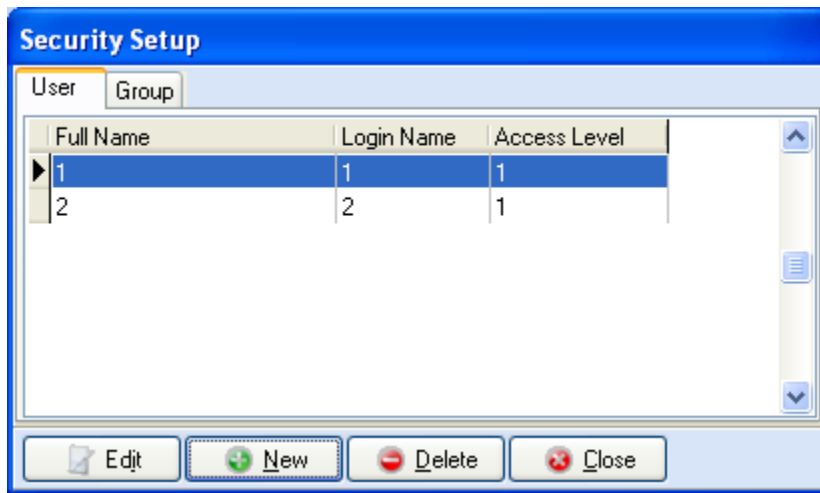
BillFlash Tab

Security Setup Overview

Medisoft Standard Security

Basic security in Medisoft is practice based with each practice having various users and groups. Multiple practices require security setup for each database. Set up security when nobody else is using the program. You create users in the User Entry window--click **File**, select **Security Setup**, and click **New**.

After you set up security, close and open the practice to apply the changes. Users that you create are displayed in the Security Setup List window.

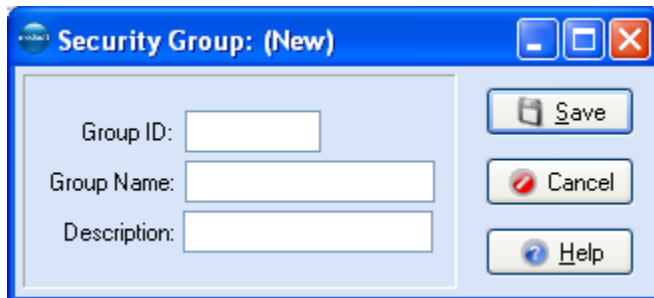


Security in Medisoft Advanced and Medisoft Network Professional allows restricted levels of access to those areas of the program that the security supervisor designates. The supervisor has unlimited access and full control of security, while other users are restricted to varying degrees. See Permissions. You can also manage password settings, such as how frequently a user must change the password. Once at least one Level 1 user has been entered, you can add more names, edit entries, or delete entries as necessary.

F1 Look up Login/Password Management.

In Medisoft Basic, you can define a user as an Administrator, which grants the user access to the Security Setup window and the ability to create users. If you are creating an administrator, make sure that you select the Administrator check box. The first user needs to be designated the Administrator.

Through the Security Setup window, you are also able to assign users to groups. Grouping users by job function or security level can help you easily assign tasks or send messages to a number of people at once.



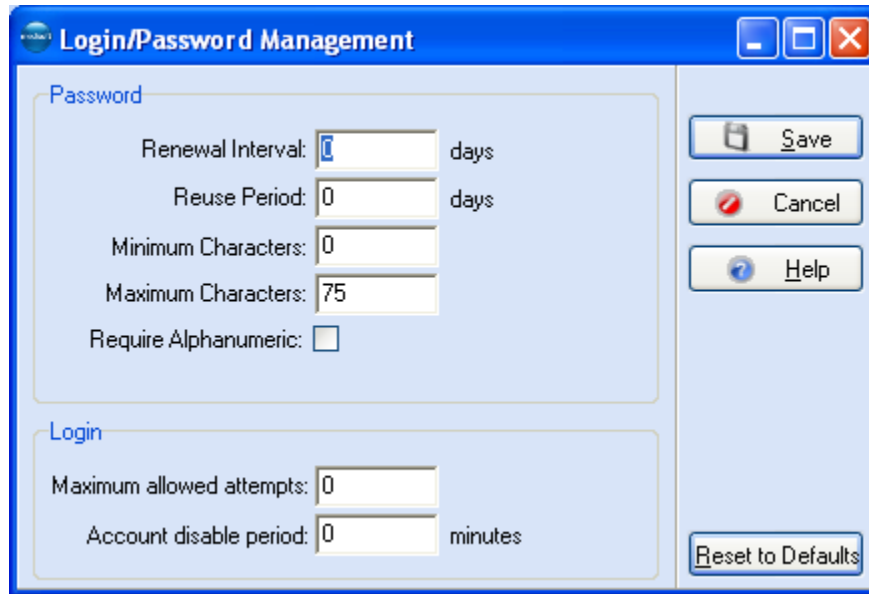
F1 Look up Medisoft Standard Security

If desired, Level One users can also set up and apply the Global Login feature. The Global Login function provides an extra layer of security and added convenience for users that access multiple practices and applications.

F1 Look up Global Login Overview.

Login/Password Management

In Login/Password Management, the supervisor sets the requirements and application of login rights and password usage. For example, you can set the length of valid passwords, the valid time frame in which a password can be used before it has to be changed, how long a user has to wait before reusing a password, etc.



F1 Look up Login/Password Management

Setting Permissions

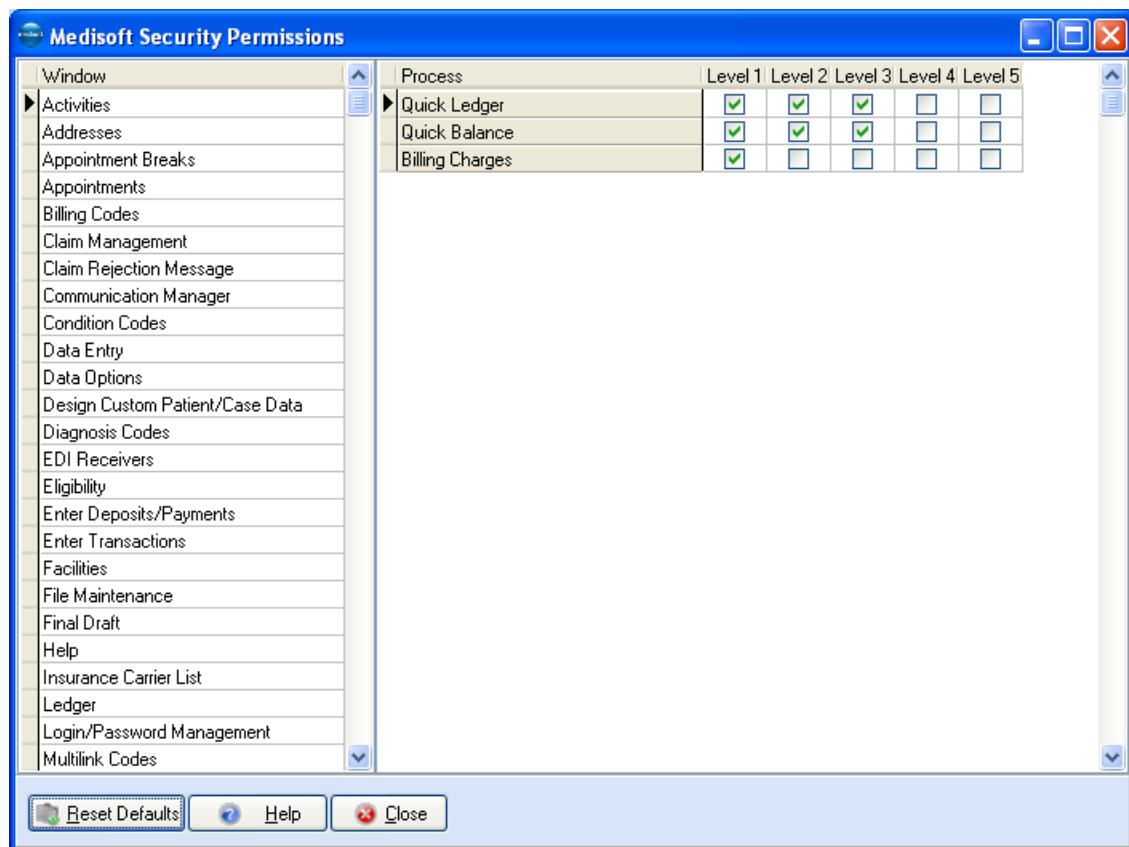
Permissions

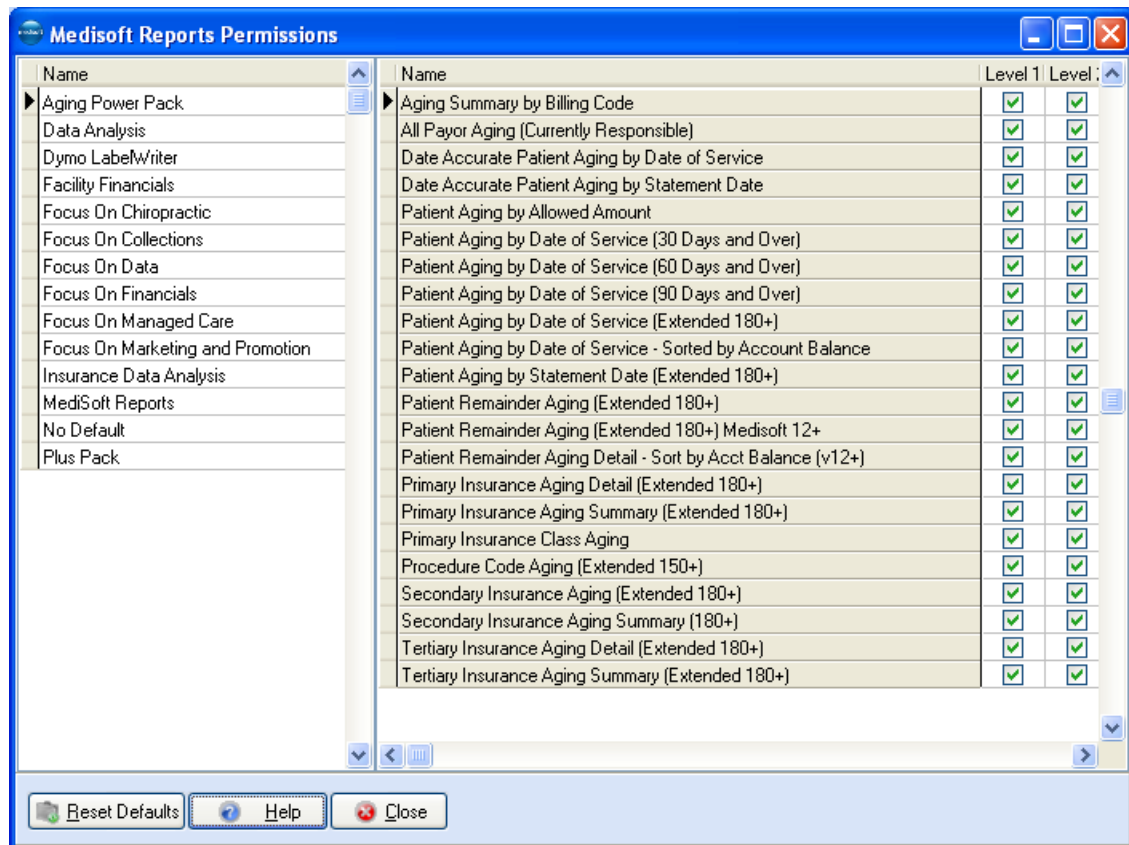
NOTE: This is an Advanced and above feature.

The Permissions feature provides five levels of access to the program. The Security Supervisor, who has unlimited access and full control of security, can assign or remove rights for any level of security, with one exception. Level 1 access cannot be removed from any of the three options listed in the **Security** window settings for the Supervisor. Lower level access can be added, but the Supervisor must retain rights to these options.

Go to the **File** menu and select **Permissions** to open the **Medisoft Security Permissions** window or select **Report Permissions** to open the **Medisoft Reports Permission** window which is used to set permissions for most reports available in Medisoft and in the Medisoft Reports engine. Permissions for most statements and other reports using the .MRE extension, however, are set in the **Medisoft Security Permissions** window.

NOTE: These options do not appear on the File menu until the security has been applied to practice with users created in the Security Setup window.





Level 1 is for unlimited access and is designed to be used exclusively by the Supervisor or administrator to restrict access to the program. Levels 2, 3, 4, and 5 can be user-defined with the Supervisor deciding what fits in what level and assigning users accordingly. Generally, the higher the level number, the fewer rights are assigned to it. Add or remove check marks for level access by clicking the appropriate check box for each process displayed with each listed window name.

If a task is attempted by a user who does not have rights to that task, based on the security level assigned, a warning dialog box is displayed stating that the user does not have the authority to perform the requested task.

Once the security feature is used, the **File** menu contains an additional option, **Log In As Another User**.

Entering Practice Information

Setup Scenarios

Before setting up a practice, consider reviewing the topic *An Overview of Setting up a Practice*. This topic reviews setup order and has links to other topics with specific instructions for setting up providers. Also consider reviewing the material in the various topics in the *Getting Started* section of the help file.

If you are a solo provider, you can use two different methods to set up your practice.

For instance, you can enter key elements such as NPI, taxonomy, and tax ID/social security number on the Practice level or in the Practice IDs grid. Then, you would need to create at least

one record (can create more if you have different requirements from various insurance carriers) on the Provider IDs grid in which you select the From Practice button for these data elements. Selecting From Practice will pull these values for claims from the Practice IDs grid.

Or, when setting up your practice (assuming you do not need to send taxonomy in Loop 2000A), you could on the Practice IDs grid select None for NPI, taxonomy, tax ID/social security number and enter a minimal amount of information of Practice IDs grid (still need at least one record). You would then create at least one record on the Provider IDs grid in which you specify your NPI, taxonomy, and tax ID/social security number.

If you are a group practice, then you will complete at least one grid entry on the Practice IDs grid for the practice. You will also create at least one grid entry on the Provider IDs grid for each provider. If you have a provider that in some instances bills using his/her own NPI number for a specific insurance carrier, you can create an extra grid entry for this provider, in which you specify the insurance company and select to pull the provider's NPI number from the Provider IDs grid.

For more information, see:

F1 Entering and Editing Practice Information

For more information, see:

F1 Entering and Editing Provider Information.

Billing Service or Different Pay To Address

If your pay to address is different from your service address, you will also need to complete the Practice Pay To tab. You will also complete this tab if you are a billing service.

Bill Flash Users

If you want to send statements electronically, you must use Bill Flash. You will also complete the Statement Pay To tab. Data on this tab is used to create a separate pay-to address location for the statements, for instance, a PO Box instead of a physical address. When you generate Bill Flash report forms in Medisoft, data is pulled from this tab.

Practice Type

The practice **Type** field is a drop-down list. Click on the arrow to view the entry options, i.e., Medical, Chiropractic, and Anesthesia. Each option controls special fields within the program.

Medical: This is the general setting for all healthcare groups except Chiropractic and Anesthesiology.

Chiropractic: Choosing Chiropractic activates the **Level of Subluxation** field in the diagnosis section of the patient case file. When set as Medical or Anesthesia, this field is not available.

Anesthesia: The Anesthesia choice adds a **Minutes** field in the **Transaction Entry** window for entering charges in transaction billing functions.

Entering Practice Information

1. Click **File** and select **Practice Information**. Click the **Practice** tab.

2. On the **Practice** tab enter the contact information for practice including practice name, address, telephone number, etc.
3. From the **Type** list select your practice type. Choices include **Medical**, **Chiropractic**, and **Anesthesia**. When you choose Chiropractic or Anesthesia, other areas in the program change accordingly. Medical is the default practice type and does not add any additional fields.

When you select **Chiropractic**, the **Level of Subluxation** field appears in the **Diagnosis** tab of the **Case** window for entering the level of subluxation. See Case (Diagnosis). In addition, five treatment fields are displayed in the Miscellaneous tab of the **Case** window electronic claims: **Treatment Months/Years**, **No. Treatments-Month**, **Nature of Condition**, **Date of Manifestation**, and **Complication Ind**. See Case (Miscellaneous).

4. In the **Federal Tax ID** field enter the practice's federal tax ID.
5. From **Practice Type**, select **Individual** or **Group**.
6. From **Entity Type**, select **Person** or **Non-Person**. Choose **Person** or **Non-Person** depending on whether the practice name consists of a practice name or an individual's name. For example, if the practice name is Western Associates Clinic, you would choose **Non-Person**. However, if the practice name is Dr. John Smith, you would choose **Person**.

NOTE: Extra 1 and Extra 2 are optional fields that may be used if a carrier requires extra data on a claim. They can hold up to 30 characters.

Entering a Practice IDs Grid Entry

Use the Practice IDs tab and Practice IDs grid to enter or edit key data elements associated with your practice (tax ID/social security number, NPI, taxonomy, legacy numbers, etc). You will set up at least one entry (rule) on the Practice IDs grid and associate this information to all providers, insurance carriers or insurance categories, and all facilities or a particular provider or carrier, and an insurance category or any combination of these elements. For more information on entering data on the IDs grid, see the topic, Assigning Rules.

This grid contains two elements. The first displays all current entries (rules). The second element, the New/Edit Practice ID window, is used to edit or create entries. The grid displays insurance carrier, insurance class, facility, NPI, Taxonomy, tax ID/ social security number and legacy data.

TIP: when creating or editing IDs grid entries, do not create matching wild card entries (all selected for insurance carrier and insurance class) since the rules engine would not know which row to select. If you had different legacy numbers, for instance in each entry, the system might not select the correct row. In this case, modify one of the wild card rows and apply it to a specific insurance carrier or class.

TIP: Press CTRL + DELETE to delete all ID entries in the Practice, Provider, Referring Provider, or Facilities IDs grids. Use this with caution since all your entries will be removed. If you have numerous legacy ID entries that no longer apply and only a few rows that need to be set up, you save time by deleting all entries and setting up the few rows you need.

1. Click **Practice IDs** tab.

Provider	Provider Class	Insurance Carrier	Insurance Class	Facility Code	NPI	Taxonomy Code	Tax ID/SSN	Legacy 1	Legacy 2
All	All	All	All	All					
JM	All	MED01	All	All					
JM	All	MED00	All	All					
JM	All	CIG00	All	All					
JM	All	BLU01	All	All				BCBS Group	
JM	All	BLU00	All	All				BCBS Group	
JM	All	AET00	All	All					

2. Click the **New** button to create a new grid entry.

--OR--

To edit an entry, select the record on the grid and click **Edit**.

3. Select the **All**, **Provider**, or **Provider Class** button.

Select the **All** button to apply the rule to all providers associated with the practice.

To apply the rule to a specific provider, select the **Provider** button and click the magnifying glass to select the specific provider.

To apply the rule to a specific provider class, select the **Provider Class** button and click the magnifying glass to select the provider class.

4. Select the **All**, **Insurance Carrier**, or **Insurance Class** button.

Select the **All** button to apply the rule to all insurance carriers associated with the practice.

To apply the rule to a specific insurance company, select the **Insurance Carrier** button and click the magnifying glass to select the insurance carrier.

To apply the rule to a specific insurance class, select the **Insurance Class** button and click the magnifying glass to select the insurance class.

5. Select either the **All** or **Facility** button.

Select the **All** button to apply the rule to all facilities associated with the practice.

To apply the rule to a specific facility, select the **Facility** button and click the magnifying glass to select the facility.

6. Select either the **None** or **National Provider ID** button.

Select the **None** button to not associate an NPI number with the rule.

Select the **National Provider ID** button and enter an NPI number to associate that NPI number with rule.

TIP: if your practice has a group NPI number, enter it here. Then, if providers in your office need to file claims as individuals, you can create a rule for that provider using the provider's individual NPI number that you enter on the Provider IDs grid.

7. Select either **None** or **Taxonomy**.

Select the **None** button to not associate a taxonomy number with the rule.

Select the **Taxonomy** button and enter a taxonomy number to associate that taxonomy number with rule. If your carrier requires this taxonomy number on a claim, you will also need to select the Send Practice Taxonomy in Loop 2000A box on the EDI/Eligibility tab of the Insurance Carrier window.

8. Select the **None**, **Tax Identifier**, or **Social Security Number** button.

Select the **None** button to not associate a tax ID or social security number with the rule.

Select the **Tax Identifier** button and enter the tax ID number to associate with the rule.

Select the **Social Security Number** button and enter the social security number to associate with the rule.

- If needed, enter up to two legacy numbers and qualifiers to associate with the rule using the **Legacy Identifier 1** and **2** fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).

For each entry select either **None** or **Legacy Identifier**.

Select the **None** button to not associate a legacy number with the rule.

To associate a legacy number with the rule (for instance a Medicare Provider Number), select the **Legacy Identifier** button, enter the legacy number, and select an ID qualifier to associate with the rule.

Entering Practice Information for a Billing Service

Billing Services

If you are a billing service, enter your client's information in the Practice tab. Enter your information in the Billing Service tab. If you want to use the Medisoft program to keep track of your own accounts receivables, a separate database can be set up with each client listed as a patient. Separate procedure codes can be created to cover the various services of your billing service.

Billing Service or Different Pay To Address

If your pay to address is different from your service address, you will also need to complete the Practice Pay To tab. You will also complete this tab if you are a billing service.

- Click **File** and select **Practice Information**. Click the **Practice Pay-To** tab.

The screenshot shows a software window titled "Practice Information" with four tabs: "Practice", "Practice IDs", "Practice Pay-To" (which is selected), and "Statement Pay-To". The "Practice Pay-To" tab contains several input fields for practice information. On the left, there are fields for "Practice Name" (containing "Happy Valley Medical Billing"), "Street" (containing "1944 N. Kluge Dr."), "Suite" (containing "8381"), "City" (containing "Gilbert"), "State" (containing "AZ"), and "Zip Code" (containing "85234"). On the right, there are fields for "Phone" (containing "(480)480-4800"), "Extension" (containing "2222"), "Fax Phone" (containing "(480)480-4801"), "Extra 1", and "Extra 2". On the far right, there are three buttons: "Save", "Cancel", and "Help".

- Enter the pay to information in the **Practice Name**, **Street**, **City**, **State**, **Zip Code**, etc. fields.

NOTE: the Extra 1 and Extra 2 fields are only used if a carrier requires extra data on a claim.

- Click **Save**.

Bill Flash Users

If you use Bill Flash for electronic statement processing, you will also complete the Statement Pay To tab. Data on this tab is used to create a separate pay-to address location for the

statements, for instance a PO Box instead of a physical address. When you generate Bill Flash report forms in Medisoft, data is pulled from this tab.

1. Click **File** and select **Practice Information**. Click the **Statement Pay-To** tab.

The screenshot shows a window titled "Practice Information" with four tabs: "Practice", "Practice IDs", "Practice Pay-To", and "Statement Pay-To". The "Statement Pay-To" tab is selected. The form contains several input fields: "Practice Name:" (a single-line text box), "Street:" (a single-line text box), "City:" (a single-line text box), "State:" (a dropdown menu), "Zip Code:" (a single-line text box), "Phone:" (a single-line text box), "Extension:" (a single-line text box), "Fax Phone:" (a single-line text box), "Extra 1:" (a single-line text box), and "Extra 2:" (a single-line text box). On the right side of the window, there are three buttons: "Save", "Cancel", and "Help".

2. Enter the pay to information in the **Practice Name**, **Street**, **City**, **State**, **Zip Code**, etc. fields.

NOTE: the **Extra 1** and **Extra 2** fields are only used if a carrier requires extra data on a claim.

3. Click **Save**.

EDI Receiver Records

The EDI Receivers window displays parameters used for transmitting information to a clearinghouse. Go to the Lists menu and select EDI Receivers. The EDI Receiver List window opens. Click Edit to modify an existing record. The EDI Receiver window opens.

The settings in Medisoft on the EDI Receivers window are used for setting rules for electronic claims generation. The actual transmission of claims is driven by Revenue Management. If you make changes on these tabs in Medisoft, the changes transmit to Revenue Management and changes made there are also transferred to Medisoft.

When sending electronic claims, you will set up your clearinghouse or direct payors in Revenue Management. Once an EDI receiver is set up, Revenue Management will synchronize the EDI settings in Medisoft. For users upgrading to Medisoft 17, Revenue Management can use the existing settings for the payors set up on the EDI Receivers window, but you will need to reconfigure receivers to work with Revenue Management.

NOTE: The Group Practice box on the EDI Receivers window IDs tab (available in Medisoft 15), is removed. This functionality is moved to the Provider window, Provider IDs tab. On this window you can assign to all insurance carriers, an insurance class, or a specific insurance carrier per provider, whether you file claims as a group or as an individual. This change provides greater flexibility since you will no longer need to possibly create two versions of the same receiver to address cases in which you had sent claims as a group and as an individual. Now, you can create as many records on the Provider IDs grid as needed to address your claim submission needs using the same receiver.

EDI Receiver: (new)

Address | Modem | ID | Extras | ERA

Code: [REDACTED] If the Code is left blank, the program will assign one.

Name: RelayHealth

Street:

City: State:

Zip Code: Inactive ☐

Phone 1: Extension:

Phone 2:

Fax Phone:

E-Mail:

Web Address:

Contact:

Comment:

Save Cancel Help

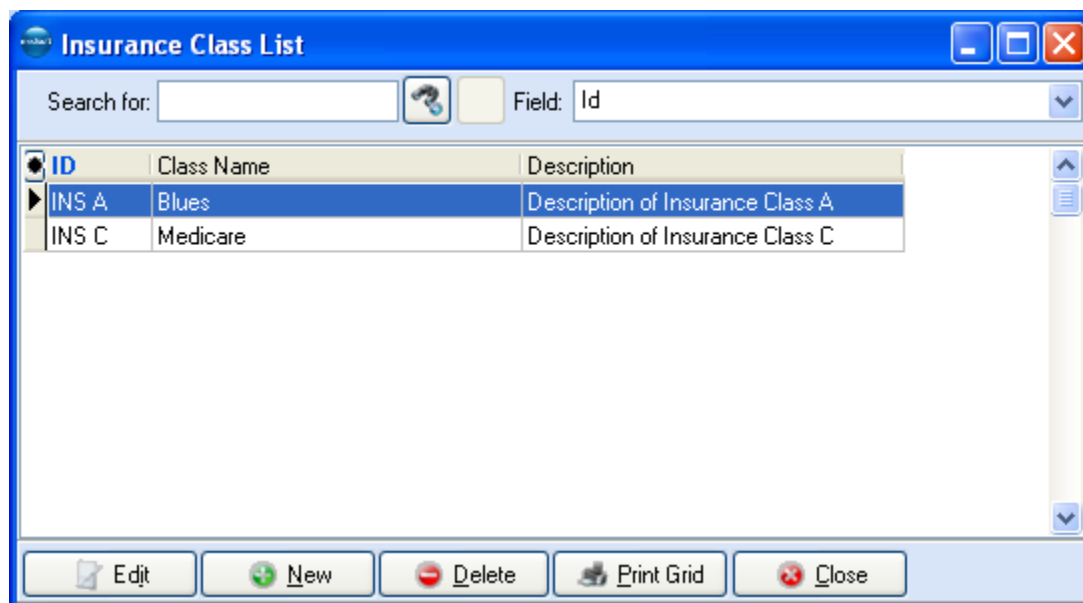
F1 Look up EDI Receiver Entry

Setting up Insurance Carriers and Insurance Classes

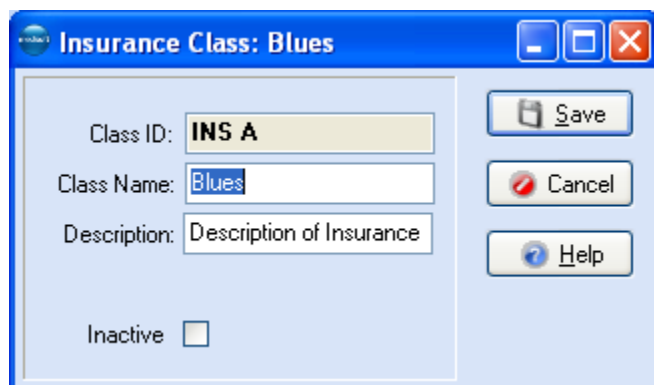
Setting up the insurance carriers correctly is essential to getting claims paid in a timely manner. Go to the **Lists** menu and select **Insurance**. Select **Carriers** from the drop-down menu or click the Insurance Carrier speed button.

Insurance Classes

Use this window to create insurance classes, such as Blue Shield or Medicare. Use these classes to group insurance carriers for easier reporting. Go to the **Lists** menu and select **Insurance**. Select **Classes** from the drop-down menu. The **Insurance Class List** window appears.



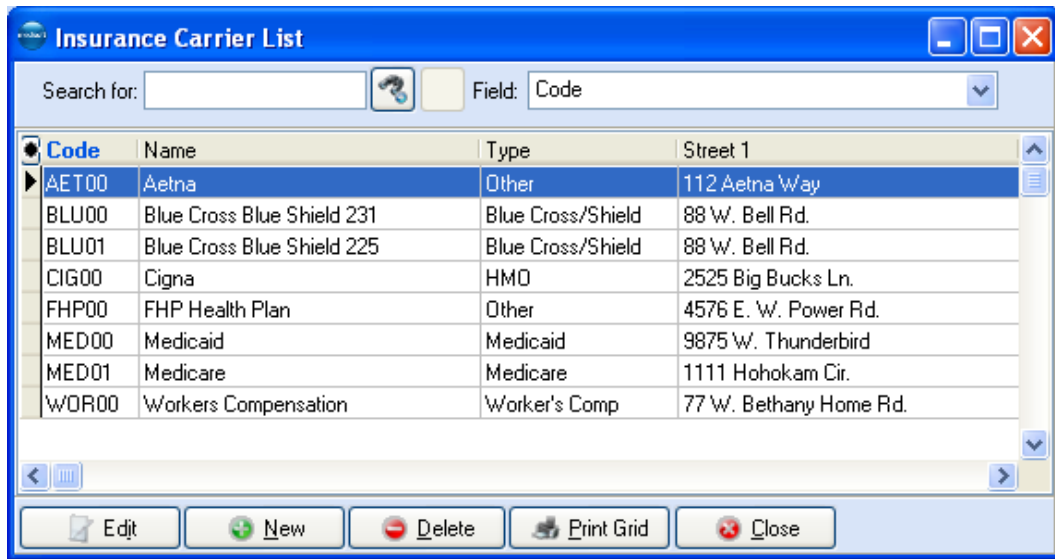
To create a new insurance class, click **New** or press **F8**. To edit a class, click **Edit** or press **F9**. Enter an **ID**, **Name**, and **Description** for the class. Insurance classes are assigned in the **Insurance Carrier Entry** window, **Options** tab.



F1 Look up Insurance Class Entry

Insurance Carriers

1. Click **Lists**, click **Insurance**, and select **Carriers**. The **Insurance Carrier List** window opens.



- Click **New**.

--OR--

Select an entry on the **Insurance Carrier List** grid and click **Edit**. The **Insurance Carrier** window opens.

- Click the **Address** tab. Enter the company's contact information in fields such as Name, Address 1, Address 2, City, State, ZIP Code, Telephone, and Fax.

In the **Contact** field, enter a contact name at the insurance carrier.

In the **Plan Name** field, enter the plan name administered by this carrier.

From the **Class** list, select an insurance class to assign to the carrier: This field lets you assign the carrier to a dynamic list of classes you create yourself. Insurance classes are then used by the rules engine for selecting an entry on the various IDs grids in the application. For more information on the rules engine and assigning rules, see the topic Assigning Rules.

NOTE: Insurance classes are created on the Insurance Class window (Lists, Insurance, Classes). For more information, see the topic Insurance Class Entry.

The screenshot shows the 'Insurance Carrier: (new)' window with the 'Address' tab selected. The window has a blue title bar and a standard Windows-style interface. The 'Address' tab is active, showing fields for 'Code', 'Carrier Address' (Name, Street, City, State, Zip Code, Phone, Extension, Fax, Contact), and 'Plan Information' (Plan Name, Class, Note). A 'Save' button is visible on the right side of the window.

4. Click the **Options and Codes** tab.

The screenshot shows the 'Insurance Carrier: (new)' window with the 'Options and Codes' tab selected. The 'Options' section includes dropdown menus for 'Procedure Code Set' (set to 1), 'Diagnosis Code Set' (set to 1), and 'CMS-1500'. Below these are fields for 'Patient Signature on File', 'Insured Signature on File', 'Physician Signature on File', and 'Print PINS on Forms', each with a dropdown menu and a box number. The 'Default Billing Method' section has three dropdown menus, all set to 'Paper'. The 'Default Payment Application Codes' section has five dropdown menus: 'Payment', 'Adjustment', 'Withhold', 'Deductible', and 'Take Back', each with a dropdown menu and a box number.

5. From the **Procedure Code** and **Diagnosis Code Set** lists, select a procedure code set (1, 2, or 3) and a diagnosis code set (1, 2, or 3) to apply to the insurance carrier. Medisoft gives you the ability to assign up to three codes to the same procedure. By using this field, the claims for each carrier can contain the correct code. For more information, see Procedure/Payment/Adjustment Entry.
6. From the **Patient, Insured, or Physician Signature on File** lists, for each option select, **Leave blank**, **Signature on file**, or **Print name**.

These fields control what is printed in the signature Boxes 12, 13, and 31, respectively, on the CMS - 1500 claim form. These fields do not control whether anything is printed in these boxes, but what is printed. Whether anything prints is controlled by settings on the **Case** window, **Policy** tab, **Accept Assignment** and **Benefits Assigned** field, and **Provider** window, **Address** tab, **Signature on File** field.

The **Signature on file** option prints "Signature on File" (if the Signature on file field has been activated in the patient and provider records).

The **Print name** option prints the name of the patient, insured, or physician.

The **Leave blank** option prints nothing.

7. From the **Print PINs on Forms** list select **PIN Only** or **Leave Blank**.

When setting up Medicare and Medicaid carriers for printed claims, select **PIN Only**; otherwise, select **Leave Blank**.

8. From the **Default Billing Method 1, 2, and 3** lists select either **Paper** or **Electronic** for handling primary (1), secondary (2), and tertiary (3) claims. Select **Paper** if claims are to be printed; select **Electronic** if claims are to be transmitted electronically.

9. In the **Default Payment Application Codes** box select default payment codes.

Payment: Click the down arrow to select a default payment code.

Adjustment: Click the down arrow to select a default adjustment code.

Withhold: Click the down arrow to select a default code for entering withhold amounts.

Deductible: Click the down arrow to select a default code for entering deductibles.

Take Back: Click the down arrow to select a default code for entering take backs.

10. Click the **EDI/Eligibility** tab. The **EDI/Eligibility** tab is mostly used for electronic claims.

11. In the **Primary Receiver** panel on the **EDI Receiver** list, click the magnifying glass and select an EDI receiver you use when sending electronic claims for primary insurances. If you do not enter an EDI receiver in the **EDI Receiver** field, electronic claims will not be created or sent for this insurance company.
12. In the **Claims Payer ID** field enter the payer ID for the insurance carrier. Refer to the enrollment information you received from the carrier/clearinghouse and look up the commercial identification number/ submitter identification numbers assigned to the insurance company by the clearinghouse.

Option: click the **Payer ID** magnifying glass to look this up using the pre-loaded database which contains many payer IDs.

13. If you use the eligibility verification service and want to verify eligibility with this insurance carrier, in the **Eligibility Payer ID** field, enter the payer ID (for some carriers, the eligibility payer ID is different from the payer ID). Refer to the enrollment information you received from the clearinghouse and look up the commercial identification number/ submitter identification numbers assigned to the insurance company by the clearinghouse.

Option: click the **Payer ID** magnifying glass to look this up using the pre-loaded database which contains many payer IDs.

14. Option: The **National Plan ID** field is not yet mandated. If you have received an ID number, enter it in this field.
15. If you file secondary claims with the insurance company, select/enter values on the Secondary Receiver panel for the **EDI Receiver**, **Claims Payer ID**, **Eligibility Payer ID**, and **National Plan ID** fields. If you do not enter an EDI receiver in this section of the window, electronic claims will not be created or sent for this insurance company for secondary claims.
16. From the **Type** list select a type for the insurance company from the following options: Automobile, Blue Cross/Shield, Central Cert, ChampsVA, Disability, EOP, FECA, Group, HMO, Indemnity, Liability, Library Medical, Medicaid, Medicare, Medicare Part A, Mutually Defined, No Charge, Other, Other Federal, Other non-federal, POS, PPO, Self-pay, Title V, Tricare/Champus, Unknown, and Worker's Compensation..
17. Leave **Alternate Carrier ID** blank. The Revenue Management feature will populate this field if needed.
18. The NDC Record Code field is also used by the Revenue Management feature.
19. If needed, select from the **EDI Max Transactions** list, a maximum number of transactions accepted by the carrier. This field is available for those carriers that limit the number of transactions per claim accepted electronically. If you submit more than the maximum number of transactions per claim, the program automatically splits the claim.
20. If the insurance carrier is used as both a primary EDI insurer and a Medigap insurer, in the **EDI Extra 1/Medigap** field, enter the Medigap number in this field. The number entered is the COBA Medigap claim-based identifier received from the national Coordination of Benefits Contractor (COBC).
21. The **EDI Extra 2** field is used by the Revenue Management feature.
22. Select the **Complimentary Crossover** box if you are filing complimentary crossover claims. Secondary insurance will not be sent in the claim file. However, the program will mark the secondary as sent. If you are sending Medigap claims, do not select this box.

23. **Delay Secondary Billing:** If there is a secondary insurance company, you can delay printing the secondary claim form until a response is recorded from the primary carrier by selecting the **Delay Secondary Billing** box. To print the secondary claim form at the same time the primary is printed, leave the box empty (which is the default setting).
24. Select the **Send Ordering Provider in Loop 2420E** box to send ordering provider information on an electronic claim.
25. Select the **Send Practice Taxonomy in Loop 2000A** box to send taxonomy in Loop 2000A for electronic claims. Loop 2000A is usually used to report taxonomy for individual providers though some carriers require here and in 2310. Contact your carrier for more on their taxonomy requirements. For more information on setting up taxonomy in Medisoft, see the topic Taxonomy.
26. Options: Click the **Allowed** tab.

Code	Procedure	Allowed
17110	Wart Removal	0.00
29130	App. of Finger Splint, Static	0.00
36215	Lab Drawing Fee	0.00
43220	Esophageal Endoscopy	0.00
70250	X-Ray, Skull, 4 Views	0.00
70360	X-Ray, Neck	0.00
70373	X-Ray, Laryngography	0.00
71020	X-Ray, Chest, 2 Views	0.00
71030	X-Ray, Chest, Min 4 Views	0.00
71040	Contrast X-Ray of Bronchitis	0.00
72052	X-Ray, Spinal, Complete	0.00
73130	X-Ray, Hand, Min 3 Views	0.00
73562	X-Ray, Knee, Min 3 Views	0.00
73610	X-Ray, Ankle, Complete	0.00
74246	MRI-Gastrointestinal Tract	0.00
74283	Barium Enema, Therapeutic	0.00
76818	U. S. Fetal Age	0.00
80050	General Health Screen Panel	0.00
81000	Urinalysis, Routine	0.00

This displays the amount last paid by the selected carrier for each procedure code available in the program. If you do not enter anything in this table, each time a carrier makes a payment on a particular procedure code, the program takes the amount paid plus any deductible and divides it by the established Service Classification percentage to arrive at the allowed amount. That amount is entered in this matrix and in a matching matrix that is part of the Procedure/Payment/Adjustment Code record.

This allowed amount is used when calculating the patient portion estimate of any procedure in the **Transaction Entry** window. The existing allowed amount can be changed in the Transaction Entry window by clicking the **Allowed Amt** column and entering the corrected amount.

27. Click **Save**.

Facility Information

Setup Scenarios

If you have a facility or a lab attached/affiliated with your practice, you will need to create a record for it. There are two components to the record: contact/demographic data entered on the **Address** tab and billing-specific information entered on the **Facility IDs** tab.

If you have enumerated a separate NPI number for your facility and need to send facility billing information in Loop 2420D or pull data for box 32 of the CMS 1500 form, you can specify the type of facility and qualifier (77- service location, FA - Facility, LI - Independent Lab, TL - Testing Laboratory, etc.) along with including a separate facility NPI number and if this information is sent on the claim by selecting the **Send Facility on Claim** check box.

Entering Contact Information

1. Click **Lists** and select **Facilities**. The **Facility List** window opens.

The screenshot shows the 'Facility List' window. It has a search bar at the top with a 'Field: Type' dropdown. Below the search bar is a table with the following data:

Code	Name	Phone	Type	Extension
DES00	Desert Valley Hospital	(602)969-5432	Facility	
J0000	J. Duckworth Mallard and A	(602)969-4237	Facility	
MES00	Mesa Community Hospital	(602)967-8792	Facility	
NEW01	New Age Medical Laborato	(602)473-2241	Laboratory	
DES01	Desert Diamond Labs	(602)333-1111	Laboratory	

At the bottom of the window are five buttons: Edit, New, Delete, Print Grid, and Close.

2. Click **New**.

--OR--

Option: select a record on the **Facility List** grid and click **Edit**.

3. Click the **Address** tab.

The screenshot shows a software window titled "Facility: (new)". It has two tabs: "Address" and "Facility IDs", with "Facility IDs" being the active tab. The form contains the following fields and controls:

- Code:** A text input field.
- Inactive:** A checkbox.
- Type:** Two radio buttons, "Facility" (selected) and "Laboratory".
- Name:** A text input field.
- Street:** A text input field.
- City:** A text input field.
- State:** A dropdown menu.
- Zip Code:** A text input field.
- Extra 1:** A text input field.
- Extra 2:** A text input field.
- Phone:** A text input field.
- Extension:** A text input field.
- Fax:** A text input field.
- Cell Phone:** A text input field.
- Office:** A text input field.
- Contact:** A text input field.
- E-Mail:** A text input field.
- Purchased Services:** A checkbox.

On the right side of the window, there are four buttons: "Save", "Cancel", "Help", and "Set Default".

4. Enter contact data associated with the facility including a name, address, telephone number, etc. If the facility is a lab, select the **Laboratory** button; if the facility is not, select **Facility**.
5. Click **Save** if finished or go to the next section for information on entering data on the **Facility IDs** tab.

Entering Information on the Facility IDs grid

Use the **Facility IDs** tab and **Facility IDs** grid to enter or edit key data elements associated with a facility (NPI number, taxonomy number, CLIA number, legacy numbers, etc.). If your practice is associated with a facility or a lab, you will set up at least one entry (rule) on the **Facility IDs** grid and associate this information to all or a specific insurance carrier or an insurance class.

For more information on entering data on the IDs grid, see the topic, Assigning Rules.

When creating or editing a facility IDs record, you will first create/modify a rule based a combination of all or of a specific insurance carrier or insurance class. When processing claims, the rules engine uses this information to select the correct entry on the grid.

The second part of creating or editing a facility ID record is to select if facility data will appear on a claim along with selecting a qualifier for the facility and associating other data elements to pull for a claim including a combination of none or a specific NPI, taxonomy number, CLIA number, and legacy data (if you need to send information in Loop 2420D or box 32 of the CMS 1500 form). After the rules engine identifies the correct row on the grid, this data is used in processing (either print or electronic) the claim.

TIP: when creating or editing IDs grid entries, do not create matching wild card entries (all selected for insurance carrier and insurance class) since the rules engine would not know which row to select. If you had different legacy numbers, for instance in each entry, the system might not select the correct row. In this case, modify one of the wild card rows and apply it to a specific insurance carrier or class.

TIP: Press CTRL + DELETE to delete all ID entries in the Practice, Provider, Referring Provider, or Facilities IDs grids. Use this with caution since all your entries will be removed. If you have numerous legacy ID entries that no longer apply and only a few rows that need

to be set up, you save time by deleting all entries and setting up the few rows you need.

1. Click the **Facility IDs** tab.

This window contains two elements. The first displays all current entries (rules). The second element, the New/Edit Facility IDs window, is used to edit or create entries. The grid displays insurance company, insurance category, NPI, Taxonomy, CLIA, and legacy data.

The screenshot shows a window titled "Facility: (new)". It has two tabs: "Address" and "Facility IDs". The "Facility IDs" tab is active, displaying a grid with the following columns: Insurance Carrier, Insurance Class, NPI, Taxonomy Code, CLIA, Legacy 1, and Legacy 2. The grid is currently empty. To the right of the grid are buttons for "Save", "Cancel", "Help", and "Set Default". At the bottom of the window are buttons for "Edit", "New", "Delete", and "Print Grid".

2. Click the **New** button to create a new grid entry.

--OR--

To edit an entry, select the record on the grid and click **Edit**.

The **New Facility** or **Edit Facility** window opens.

The screenshot shows a window titled "New Facility ID". It contains several input fields and radio buttons. At the top, there are radio buttons for "All", "Insurance Carrier", and "Insurance Class". Below these are checkboxes for "Send Facility On Claim" and "ID Qualifier". There are also radio buttons for "None", "National Provider ID", "Taxonomy", "CLIA", "Legacy Identifier 1", and "Legacy Identifier 2". Each of these radio buttons is followed by a text input field. On the right side of the window are buttons for "OK", "Cancel", and "Help".

3. Select either **All**, **Insurance Carrier**, or **Insurance Class**.

Select the **All** button to apply the rule to all insurance carriers associated with the facility.

To apply the rule to a specific insurance carrier, select the **Insurance Carrier** button and click the magnifying glass to select the insurance carrier.

To apply the rule to a specific insurance class, select the **Insurance Class** button and click the magnifying glass to select the insurance class.

4. To include facility information on a print or electronic claim (box 32 CMS 1500 form and Loop 2420D), select the **Send Facility on Claim** box and the select an ID Qualifier. Leave the box blank (unchecked) to not include facility information on a claim.
5. Select either **None** or **National Provider ID**.

Select the **None** button to not associate an NPI number with the rule.

Select the **National Provider ID** button and enter an NPI number to associate the facility NPI number with rule.

6. Select either **None** or **Taxonomy**.

Select the **None** button to not associate a taxonomy number with the rule.

Select the **Taxonomy** button and enter a taxonomy number to associate that taxonomy number with rule.

7. Select either **None** or **CLIA**.

Select the **None** button to not associate a CLIA number with the rule.

Select the **CLIA** button and enter a facility CLIA number to associate with rule.

8. If needed enter up to two legacy numbers and qualifiers to associate with the rule using the **Legacy Identifier 1** and **2** fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).

For each entry select either **None** or **Legacy Identifier**.

Select the **None** button to not associate a legacy number with the rule.

To associate a legacy number with the rule, select the **Legacy Identifier** button, enter the legacy number, and select an ID qualifier to associate with the rule.

9. Click **Save**.

Setting up Providers and Provider Classes

The **Provider List** is accessed by going to the **Lists** menu and selecting **Providers** or by clicking the Provider List speed button. Specific provider information is accessed by clicking **Edit** or pressing **F9**, and the **Provider: (new)** setup window is accessed by clicking **New** or pressing **F8**.

Provider Class Records

Use this window to enter classes or groups for providers in your practice. Grouping providers into classes is helpful when sending claims or statements electronically. Go to the **Lists** menu and select **Provider**. Select **Class** from the drop-down menu. To create a new class of providers, click **New** or press **F8**. To edit a class, click **Edit** or press **F9**. The **Provider Class List** window appears. Enter a **Class ID**, **Class Name**, and **Description**. Provider classes are assigned to specific providers in the **Providers** window, **Reference** tab.

F1 Look up Provider Class Entry

Setup Scenarios

If you are a solo provider, you can use two different methods to set up your practice.

If you are a solo provider (file claims as an individual) with the same pay to as your billing address (the Pay To tab is blank), you can enter your NPI information on the Practice IDs grid. In this case, you would select on the Providers IDs grid the From Practice button instead of selecting the National Provider ID button and entering an NPI number.

If you are a solo provider with different billing information and pay to information (the Pay To tab is complete), you can enter your NPI information on the Provider IDs grid. In this case, you would select on the Providers IDs grid the National Provider ID button and enter your NPI number. Entering the NPI number on the practice level is required in this case to pull your NPI number in Loop 2010AB. If you left the NPI number only on the practice level, it would not pull for this loop.

If you are a solo provider with insurance carriers that require mixed NPI numbers (some require individual while some require a group) you would enter your group NPI number on the Practice IDs grid. You would then create an entry on the Provider IDs grid in which you would enter your individual NPI number on Provider IDs grid and apply it to all insurance carriers, an insurance class, or a carrier (you could create several records if needed to address other issues such as legacy numbers, taxonomy, etc.). For those carriers that require the group NPI, you would create at least one other separate entry on the Providers IDs grid (might need more depending on other issues such as legacy numbers, taxonomy, etc.) for that carrier or that insurance class in which you select the From Practice button instead of selecting the National Provider ID button and entering an NPI number.

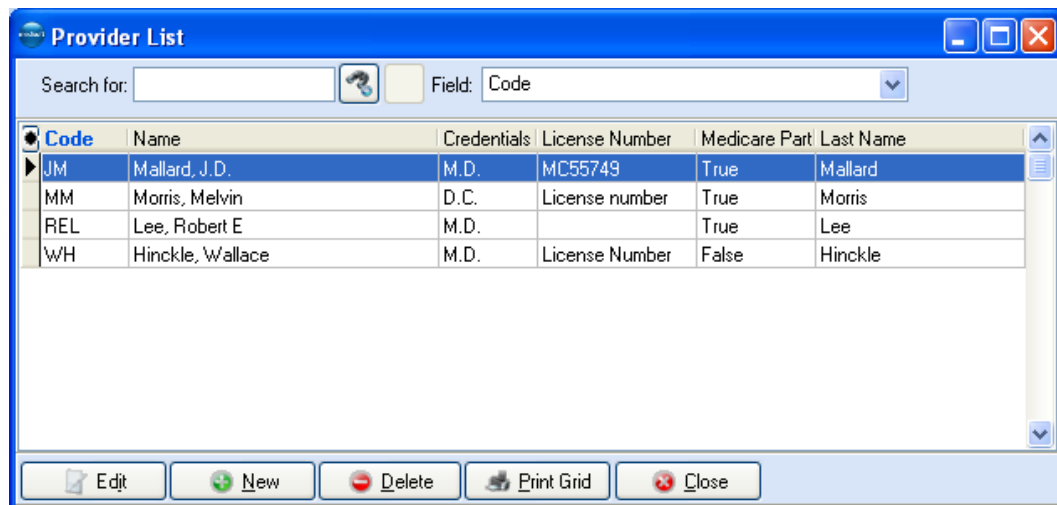
If you are a group practice, you will complete at least one grid entry on the Practice IDs grid for the practice. You will also create at least one grid entry on the Provider IDs grid for each provider. If you have a provider that in some instances bills using his/her own NPI number for a specific insurance carrier, you can create an extra grid entry for this provider in which you specify the insurance company and select to pull the provider's NPI number from the Provider IDs grid.

For more information, see:

F1 Entering and Editing Provider Information

Entering Provider Information

1. Click **Lists**, select **Provider** and select **Providers**. The **Provider List** window opens.



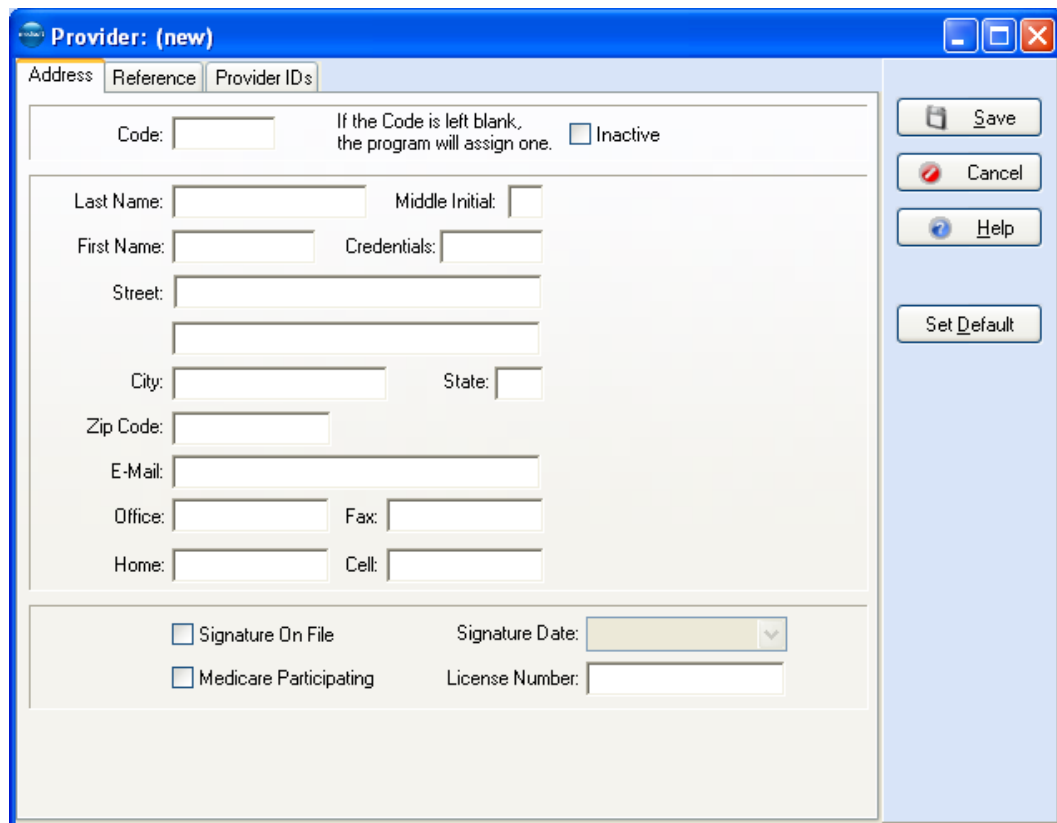
The **Provider List** window displays a table of providers. At the top, there is a search bar and a dropdown menu set to 'Code'. The table has columns for Code, Name, Credentials, License Number, Medicare Part, and Last Name. Below the table are buttons for Edit, New, Delete, Print Grid, and Close.

Code	Name	Credentials	License Number	Medicare Part	Last Name
JM	Mallard, J.D.	M.D.	MC55749	True	Mallard
MM	Morris, Melvin	D.C.	License number	True	Morris
REL	Lee, Robert E	M.D.		True	Lee
WH	Hinckle, Wallace	M.D.	License Number	False	Hinckle

2. Click **New**.

--OR--

Select an entry on the **Provider List** window and click **Edit**. The **Provider** window opens.



The **Provider: (new)** window is used to enter provider information. It has tabs for Address, Reference, and Provider IDs. The Address tab is active, showing various input fields for personal and contact information. On the right side, there are buttons for Save, Cancel, Help, and Set Default.

Address | Reference | Provider IDs

Code: If the Code is left blank, the program will assign one. ☐ Inactive

Last Name: Middle Initial:

First Name: Credentials:

Street:

City: State:

Zip Code:

E-Mail:

Office: Fax:

Home: Cell:

☐ Signature On File Signature Date:

☐ Medicare Participating License Number:

Save Cancel Help Set Default

3. Click the **Address** tab and enter demographic information for the provider such as last name, first name, title, etc.
4. Options:

Select the **Medicare Participating Provider** box if the provider is considered a Medicare participating provider. A Medicare participating provider agrees to accept assignment on all Medicare claims for covered services and supplies. This field is generally used with electronic claims.

Select the **Signature on File** box to indicate that the provider's signature is on file. Select this box if the provider has signed an agreement with Medicare to accept its charges and an affidavit is on file. If it is checked, the **Signature Date** field becomes active to display the date on which the signature was placed on file. To enter a date in this field, either type the date or click in the **Signature Date** field or click the down arrow to the right of the field and the calendar opens.

5. In the **License** field enter the provider's license number.
6. Click **Save** if you are finished with the record or click the **Reference** tab.

The **Reference** tab displays data and values before the data was converted to Medisoft 17 and moved to the **Provider IDs** grid to create rules for claim creation. The tab shows data from the **Default Pins** and **Default Group IDs** tabs, which were replaced in Medisoft 17 with the Provider IDs tab.

This tab is mostly used for reference purpose only. You can update data on this tab for your reference purposes, but none of this data is pulled for claim generation--the rules engine does not pull any of this data from this tab. The only field that still impacts claims is the **Provider Class** list.

Provider: (new)

Address Reference **Provider IDs**

EDI Receiver Override: [] [v] [?] Provider Class: [] [v] [?]

PINS

Medicare: []

Medicaid: []

Tricare: []

Blue Cross/Shield: []

Commercial: []

PPO: []

HMO: []

Group Numbers

Group Number: []

Medicare Group ID: []

Medicaid Group ID: []

BC/BS Group ID: []

Other Group ID: []

UPIN: []

Extra 1: [] Extra 2: []

EDI ID: [] Payee Number: []

CLIA Number: [] TAT Number: []

☐ Hospice Emp:

Save Cancel Help Set Default

7. **Option:** Assign a provider to a provider class by clicking the **Provider Class** list and selecting a class.

NOTE: Provider classes are set up in the Provider Class List.

When generating claims, the provider class can be used on the Practice IDs tab to limit a grid entry rule to a class of providers. You can change a provider's class on this tab to put the provider in a different class which in turn would impact the grid entry that is selected on the Practice IDs grid.

8. Click **Save** if you are finished with the record or click the **Provider IDs** tab and go to the next section Entering Provider IDs Grid Entries.

Entering Provider IDs Grid Entries

Use the **Provider IDs** tab and **Provider IDs** grid to enter or edit key data elements associated with a provider (tax ID/social security number, NPI, taxonomy, legacy numbers, etc). You will set up at least one entry (rule) on the **Provider IDs** grid for each provider in your practice and associate this information to all insurance carriers or insurance classes and all facilities or a particular insurance carrier or an insurance class or any combination of these elements.

When creating or editing a provider IDs record, you will first create/modify a rule based a combination of all or of a specific insurance carrier or insurance class and facility. When processing claims, the rules engine uses this information to select the correct entry on the grid.

This grid contains two elements. The first displays all current entries (rules). The second element, the **New/Edit Provider ID** window, is used to edit or create entries. The grid displays insurance carrier, insurance class, facility, NPI, Taxonomy, tax ID/ social security number, mammography certificate numbers, CLIA numbers, care plan oversight numbers, and legacy data.

Provider: (new)

Address Reference **Provider IDs**

Insurance Carrier	Insurance Class	Facility Code	NPI	Taxonomy Code	Tax ID/SSN	Mamm Cert

Save Cancel Help

Set Default

Edit New Delete Print Grid

After the rules engine identifies the correct row on the grid, this data is used in processing (either print or electronic) the claim.

For more information on entering data on the IDs grid, see the topic, [Assigning Rules](#).

TIP: when creating or editing IDs grid entries, do not create matching wild card entries (all selected for insurance carriers and insurance class) since the rules engine would not know which row to select. If you had different legacy numbers, for instance in each entry, the system might not select the correct row. In this case, modify one of the wild card rows and apply it to a specific insurance carrier or class.

TIP: Press CTRL + DELETE to delete all ID entries in the Practice, Provider, Referring Provider, or Facilities IDs grids. Use this with caution since all your entries will be removed. If you have numerous legacy ID entries that no longer apply and only a few rows that need to be set up, you save time by deleting all entries and setting up the few rows you need.

1. Click the **Provider IDs** tab. Click the **New** button to create a new grid entry.

--OR--

To edit an entry, select the record on the grid and click **Edit**. The **New/Edit Provider ID** window opens.

2. Select either **All**, **Insurance Carrier**, or **Insurance Class**.

Select the **All** button to apply the rule to all insurance companies associated with the provider.

To apply the rule to a specific insurance carrier, select the **Insurance Carrier** button and click the magnifying glass to select the insurance carrier.

To apply the rule to a specific insurance class, select the **Insurance Class** button and click the magnifying glass to select the insurance class.

3. Select either **All** or **Facility**.

Select the **All** button to apply the rule to all facilities associated with the provider (select this option if there are no facilities associated with the provider).

To apply the rule to a specific facility, select the **Facility** button and click the magnifying glass to select the specific provider.

4. Select either **File Claim As Individual** or **File Claim As Group**.

Select the **Individual** button if the provider is a solo practitioner or files claims as an individual.

Select the **Group** button if the provider is a member of a group practice or files claims as a group.

5. Select either **From Practice** or **National Provider ID**.

TIP: If you do not want to send an NPI number on a claim, select **From Practice** and then on the **Practice IDs** window, create a matching entry for the provider in which you select **None** for the NPI option.

Select the **From Practice** button to pull NPI number from the **Practice IDs** grid.

Select the **National Provider ID** button and enter an NPI number to associate that NPI number with the rule.

6. Select either **From Practice** or **Taxonomy**.

TIP: If you do not want to send a taxonomy number on a claim, select **From Practice** and then on the **Practice IDs** window, create a matching entry for the provider in which you select **None** for the **Taxonomy** option.

Select the **From Practice** button to pull the taxonomy number from the **Practice IDs** grid.

Select the **Taxonomy** button and enter a taxonomy number to associate that taxonomy number with the rule.

7. Select **From Practice**, **Tax Identifier**, or **Social Security Number**.

Select the **From Practice** button to pull the tax ID/social security number from the **Practice ID** grid.

Select the **Tax Identifier** button and enter the tax ID number to associate with the rule.

Select the **Social Security Number** button and enter the social security number to associate with the rule.

8. If you file mammography claims, select the **Mammography Cert** button and enter the certificate number to associate with the rule. Select the **None** button to not associate a mammography certificate number with the rule.
9. If you file laboratory claims using a CLIA number, select the **CLIA** button and enter the CLIA number to associate with the rule. Select the **None** button to not associate a CLIA number with the rule.
10. If your carrier requires a care plan oversight number, select the **Care Plan Oversight** button, enter the care plan oversight number, and select an ID qualifier to associate with the rule. Select the **None** button to not associate a care plan oversight number with the rule.
11. If needed, enter up to three legacy and qualifiers to associate with the rule using the **Legacy Identifier 1, 2, and 3** fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).

For each entry, select either **None** or **Legacy Identifier**.

Select the **None** button to not associate a legacy number with the rule.

To associate a legacy number with the rule (for instance a Medicare Provider Number), select the **Legacy Identifier** button, enter the legacy number, and select an ID qualifier, and to associate with the rule.

12. Click **Save**.

Referring Provider Records

Many patient visits are the result of a referral from another provider. When a patient is referred to your practice, add data such as the Unique Physician Identification Number (UPIN), NPI, tax ID, etc.

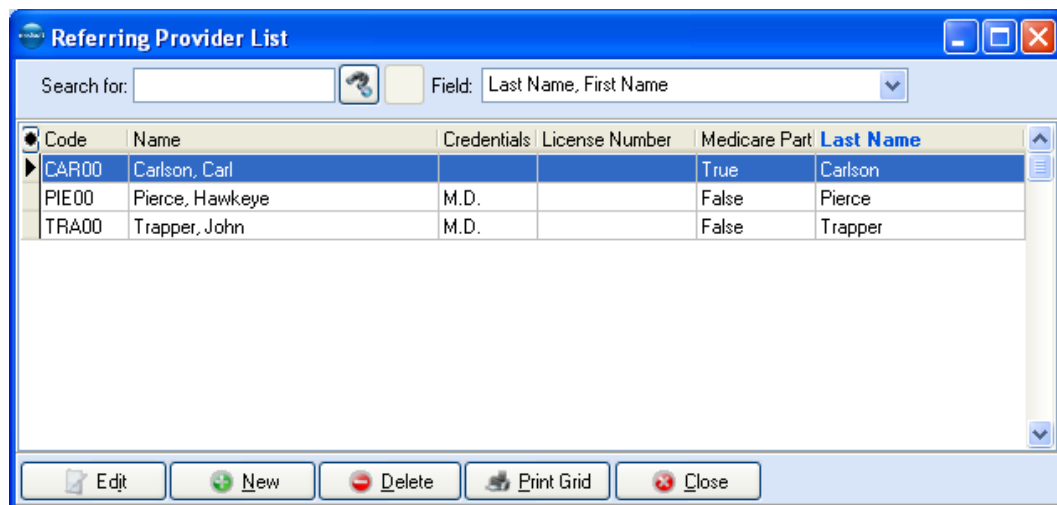
Go to the **Lists** menu and select **Referring Providers**. To enter a new referring provider record, press **F8** or click **New**.

Setup Scenarios

If you have referring providers affiliated with your practice, you will need to create a record for each referring provider. In this record, you can link the provider to a particular insurance company/category, if needed, and include other billing details such as the referring provider's NPI, taxonomy, and other legacy IDs.

Entering Contact Information

1. Click **Lists** and click **Referring Providers**. The **Referring Provider** List window opens.



2. Click **New**.

--OR--

Select a record on the **Referring Provider List** grid and click **Edit**.

The **Referring Provider** window appears.

3. Click the **Address** tab.

4. On the **Address** tab enter demographic information for the referring provider such as last name, first name, title, etc.

Also, if you are sending electronic claims, select from the **Specialty** list, the referring provider's special field of practice. If you need to use a specialty code that is different than the usual code, select "Not Listed" and enter your specialty code in the data entry box that appears next to the **Specialty** list.

NOTE: This field is not used for sending paper claims unless you have modified your claim form to include this information.

5. Click **Save** if finished or go to the next section for information on entering data on the **Referring Providers IDs** tab.

Entering Information on the Referring Provider IDs Grid

Use the Referring Provider IDs tab and grid to enter or edit key data elements associated with a referring provider (NPI, taxonomy, legacy numbers, etc). You will set up at least one entry (rule) on the Referring Provider IDs grid for each referring provider that works with your practice and associate this information to all insurance carriers or insurance classes or a particular insurance carrier or an insurance class.

When creating or editing a referring provider IDs record, you will first create/modify a rule based a combination of all or of a specific insurance carrier or insurance class. When processing claims, the rules engine uses this information to select the correct entry on the grid.

After the rules engine identifies the correct row on the grid, this data is used in processing (either print or electronic) the claim.

The second part of creating or editing a referring provider record is associating data to pull for a claim including selecting whether the referring provider's entity type (person or non-person), along with a combination of a specific NPI, Taxonomy, and legacy data. For these values, you can either include a value or select None to not include a value.

TIP: when creating or editing IDs grid entries, do not create matching wild card entries (all selected for insurance carrier and insurance class) since the rules engine would not know which row to select. If you had different legacy numbers, for instance in each entry, the system might not select the correct row. In this case, modify one of the wild card rows and apply it to a specific insurance carrier or class.

TIP: Press CTRL + DELETE to delete all ID entries in the Practice, Provider, Referring Provider, or Facilities IDs grids. Use this with caution since all your entries will be removed. If you have numerous legacy ID entries that no longer apply and only a few rows that need to be set up, you save time by deleting all entries and setting up the few rows you need.

1. Click **Referring Provider IDs** tab. This grid contains two elements. The first displays all current entries (rules). The second element, the New/Edit Referring Provider IDs window, is used to edit or create entries. The grid displays insurance carrier, insurance class, NPI, Taxonomy, and legacy data.

The screenshot shows a software window titled "Provider: (new)". It has three tabs: "Address", "Reference", and "Provider IDs", with "Provider IDs" being the active tab. The main area is a grid with the following headers: "Insurance Carrier", "Insurance Class", "Facility Code", "NPI", "Taxonomy Code", "Tax ID/SSN", and "Mamm Cert". The grid is empty. To the right of the grid are four buttons: "Save", "Cancel", "Help", and "Set Default". At the bottom of the window, there are four buttons: "Edit", "New" (highlighted with a green plus icon), "Delete", and "Print Grid".

2. Click the **New** button to create a new grid entry.

--OR--

Select an entry on the grid and click **Edit**. The **Referring Provider ID** window opens.

3. Select either **All**, **Insurance Carrier**, or **Insurance Class**.

Select the **All** button to apply the rule to all insurance carriers associated with the referring provider.

To apply the rule to a specific insurance carrier, select the **Insurance Carrier** button and click the magnifying glass to select the insurance carrier.

To apply the rule to a specific insurance class, select the **Insurance Class** button and click the magnifying glass to select the insurance category.

4. Select either **Entity Type: Person** or **Entity Type: Non-Person**.

Select the **Person** button if the referring provider is a person and not an organization.

Select the **Non-Person** button if the referring provider is an organization.

5. Select either **None** or **National Provider ID**.

Select the **None** button to not include a referring provider's NPI with the rule.

Select the **National Provider ID** button and enter an NPI number to associate that NPI number with the rule.

6. Select either **None** or **Taxonomy**.

Select the **None** button to not include a taxonomy number with the rule.

Select the **Taxonomy** button and enter a taxonomy number to associate that taxonomy number with the rule.

7. If needed, enter up to two legacy numbers and qualifiers to associate with the rule using the **Legacy Identifier 1** and **2** fields. Use these fields to customize your rule to meet filing requirements with an insurance carrier(s).

For each entry select either **None** or **Legacy Identifier**.

Select the **None** button to not associate a legacy number with the rule.

To associate a legacy number with the rule (for instance a Medicare Provider Number),

select the **Legacy Identifier** button, enter the legacy number, and select an ID qualifier to associate with the rule.

8. Click **Save**.

Attorney, Employer, or Other Addresses

The Address file is your address book within the computer. It keeps the names, addresses, and phone numbers (with extensions) of important outside contacts, such as attorneys, employers, referral sources, etc. Facilities and referring providers are set up in the Facility file and Referring Provider file.

The Address file should include all important contact persons whose phone, fax, cell, and e-mail numbers the practice needs at any time in the future.

Go to the **Lists** menu and select **Addresses** or click the Address List icon.

When you click **New** or press **F8**, the program automatically assigns an address code based upon the **Name** field. The address code is not assigned until all information is entered and saved. Use **Search for** and **Field** to look up the address code of existing records.

The addresses maintained in the program are classified by "type" assigned to facilitate ease of selection in a drop-down list. These types include: **Attorney**, **Employer**, **Miscellaneous**, and **Referral Source**.

F1 Look up Address Entry

Use the **Address** window to enter information for attorneys, employers, and other entities. To set up address records, click **Lists** and select **Addresses**. The **Address List** window opens.

The screenshot shows the 'Address List' window with a search bar and a table of records. The table has columns for Code, Name, Phone, Type, and Extension. The records listed are:

Code	Name	Phone	Type	Extension
JOR00	J.R. Ewing	(602)938-0002	Attorney	
ANG00	Angela Mason	(602)457-1666	Attorney	
ARM00	Army		Employer	
BEA00	BeanSprout Express	(602)453-9988	Employer	
DOO00	Doomart		Employer	
MIC00	Micro Mania Inc.	(602)746-2134	Employer	
NEW00	News Channel 11		Employer	
REA00	Really Useful Trucking Co.	(602)457-3326	Employer	
WIN00	Windham Gallery	(602)893-4215	Employer	
SA000	S and A Bank		Employer	

At the bottom of the window are buttons for Edit, New, Delete, Print Grid, and Close.

To set up Address Records

1. Click **New** on the **Address List** window.

--OR--

Option: to edit an existing record, select the record on the **Address List** grid and click

Edit.

2. In the **Address Code** field, enter a code for a new address record, or leave the field blank and let the program create a unique code.

3. From the Type list, select **Attorney, Employer, Miscellaneous, or Referral Source**.

NOTE: A facility record is entered on the **Facility** window (**Lists, Facilities**). For more information, see Facility Entry.

Enter other demographic data such as name, telephone numbers, email address, etc.

4. Click **Save**.

Procedure, Payment, and Adjustment Codes

Procedure codes are used to communicate procedure information between patient, provider, and third-party payers. These codes can be accessed by going to the **Lists** menu and selecting **Procedure/Payment/Adjustment Codes**.

The **Procedure/Payment/Adjustment List** window shows what codes have been set up.

Code 1	Description	Amount	Type Description
17110	Wart Removal	\$15.00	Procedure charge
29130	App. of Finger Splint, Static	\$30.00	Procedure charge
43220	Esophageal Endoscopy	\$275.00	Procedure charge
70250	X-Ray, Skull, 4 Views	\$55.00	Procedure charge
70360	X-Ray, Neck	\$45.00	Procedure charge
71020	X-Ray, Chest, 2 Views	\$53.00	Procedure charge
71030	X-Ray, Chest, Min 4 Views	\$65.00	Procedure charge
71040	Contrast X-Ray of Bronchitis	\$50.00	Procedure charge
72052	X-Ray, Spinal, Complete	\$80.00	Procedure charge

At the top of the window, there are two fields to help you find a procedure code: **Search for** and **Field**. **Field** defaults to **Type** but can be changed to **Code 1** or **Description**. If you are not sure of the complete code, description, or type, enter the first few letters or numbers in the **Search for** field. As you type, the list automatically filters to display records that match. At the bottom of the window are choices for setting up a new code, editing a code, or deleting a code. If the code you need is not shown in the list, click **New** or press **F8**.

F1 Look up Procedure/Payment/Adjustment Entry

General Tab

In this area, you can enter a new code number, description, and type. Valid code types can be seen by clicking on the drop-down **Code Type** list.

Procedure/Payment/Adjustment: (new)

General | Amounts | Allowed Amounts

Code 1: ☐ Inactive

Description:

Code Type: Procedure charge ▼

Account Code:

Type of Service:

Place of Service:

Time To Do Procedure: 0

Service Classification: A ▼

Don't Bill To Insurance:

Only Bill To Insurance:

Default Modifiers:

Revenue Code: ▼ ⓘ

Default Units: 0

National Drug Code:

NDC Unit Price:

NDC Unit of Measurement: ▼

Code ID Qualifier:

Purchase Service Amount:

☐ Taxable
☐ HIPAA Approved
☐ Require Co-pay
☐ HCPCS Code

☐ Patient Only Responsible
☐ Purchased Service

Alternate Codes

2:

3:

HCPCS Rate Code:

Save Cancel Help

Accounting Codes can be any configuration of letters or numbers you want to assign to each accounting function, e.g., cash, checks, etc. Procedure codes are used for recording charges for services rendered, and Accounting Codes show the payment and adjustment side of the entry process. These categories are broken down into codes for specific purposes.

Valid codes that have unique functions within the program are:

Adjustment	Deductible
Billing Charge	Inside Lab Charge
Cash Co-payment	Insurance Adjustment
Cash Payment	Insurance Payment
Check Co-payment	Insurance Withhold Adjustment
Check Payment	Outside Lab Charge
Comment	Procedure Charge
Credit Card Co-payment	Product Charge

Credit Card Payment

Tax

Also indicated in this window are the type of service, place of service, time to perform the procedure, whether to allow the code to print on insurance forms, Alternate Codes and, if applicable, whether only the patient is responsible. There is also a check box to indicate if the code is inactive.

Modifiers help pinpoint the exact procedure performed. If needed for claim filing, add modifiers. The **HIPAA Approved** field indicates whether the code is HIPAA approved. The **Revenue Code** is used with the UB92 claim form. You can adjust the number of units associated with this code in the **Default Units** field. If the code is used only with a service that the practice purchased (usually from a lab), click this check box.

F1 Look up Procedure/Payment/Adjustment Entry-General Tab

Amounts Tab

The Amounts tab is linked with **Case** information, Account tab, **Price Code** field. Medisoft Advanced and Medisoft Network Professional allow 26 charge amounts for each code entered in the program. The applicable charge amount is selected in the Account tab of each patient's **Case** window.

Procedure/Payment/Adjustment: App. of Finger Splint, Static

General | **Amounts** | Allowed Amounts

Charge Amounts

A: 30.00	H: 0.00	O: 0.00	V: 0.00
B: 0.00	I: 0.00	P: 0.00	W: 0.00
C: 0.00	J: 0.00	Q: 0.00	X: 0.00
D: 0.00	K: 0.00	R: 0.00	Y: 0.00
E: 0.00	L: 0.00	S: 0.00	Z: 0.00
F: 0.00	M: 0.00	T: 0.00	
G: 0.00	N: 0.00	U: 0.00	

Cost of Service/Product: 5.00 Medicare Allowed Amount: 0.00

Save Cancel Help

F1 Look up Procedure/Payment/Adjustment Entry-Amounts Tab

Allowed Amounts Tab (Advanced and above)

The Allowed Amounts tab keeps track of how much each carrier pays for a particular code. The program calculates the allowed amount based on the amount paid, any applicable deductible, and the service classification. This amount is used in calculating the patient portion of any transaction entered in **Transaction Entry**.

Procedure/Payment/Adjustment: App. of Finger Splint, Static

General | Amounts | **Allowed Amounts**

Insurance Name	Code	Modifiers	Amount
▶ Aetna	AET00		0.00
Blue Cross Blue Shield 225	BLU01		0.00
Blue Cross Blue Shield 231	BLU00		0.00
Cigna	CIG00		0.00
FHP Health Plan	FHP00		0.00
Medicaid	MED00		0.00
Medicare	MED01		0.00
U.S. Tricare	US000		0.00
Workers Compensation	WOR00		0.00

Save Cancel Help Delete

F1 Look up Procedure/Payment/Adjustment Entry-Allowed Amounts Tab

MultiLink Codes

MultiLinks are groups of procedure codes combined under one access code. They are for procedures that are normally performed at the same time, e.g., for a physical exam, a routine set of treatments, etc.

The advantages to using MultiLinks include a reduction of time during data entry. If you can create several transactions with the entry of a single code name or number, there is an obvious time saving. MultiLinks also reduce omission errors. You won't forget codes that should be included if they are included in a MultiLink. When you use the MultiLink code, all the codes in the group are entered.

Enter the MultiLinks function by going to the **Lists** menu and selecting **MultiLink Codes**.

MultiLink List

Search for: Field: Code

Code	Description	Link Code 1	Link Code 2	Link Code 3	Link Cod
CATHET0000	Catheterization	99213	87087	97086	
DIABET0000	Diabetes Screening	99214	82947	36215	99000
LOV0000000	LOV	99213	97260	97010	97128
TRUCKE0000	Trucker Physical	99214	93000	99000	DS
WELLC00000	Well Check Exam (2 months)	29130	36215	36215	

Buttons: Edit, New, Delete, Print Grid, Close

The list displays all available procedure codes, adjustment codes, and payment codes. You can also set up a new MultiLink or edit or delete an existing MultiLink code by clicking **Edit** or **New**.

MultiLink Code: Catheterization

Code: **CATHET0000**

Inactive ☐

Description:

Link Codes

1:	99213	Office Visit Est. Patient EEL
2:	87087	Commercial Kit
3:	97086	Catheterization
4:		
5:		
6:		
7:		
8:		

Buttons: Save, Cancel, Help

F1 Look up MultiLink Entry

Diagnosis Codes

Diagnosis codes represent the reason a service is provided. In effect, the procedure code tells what the doctor did and the diagnosis code tells what the doctor found.

As with other list functions, the diagnosis code setup is accessed by going to the **Lists** menu and selecting **Diagnosis Codes**.

The 'Diagnosis List' window displays a table with four columns: Code 1, Description, Code 2, and Code 3. The table contains the following data:

Code 1	Description	Code 2	Code 3
726.71	Achilles Tendonitis	726.71	726.71
493.9	Allergic Bronchitis	493.9	493.9
995.3	Allergic Reaction/Allergies	995.3	995.3
783.0	Anorexia	783.0	783.0
716.9	Arthritis, Multiple	716.9	716.9
716.94	Arthritis-Hand	716.94	716.94
110.4	Athlete's Foot	110.4	110.4
847.2	Back Spasm	847.2	847.2
786.09	Breathing Difficulty	786.09	786.09
490.0	Bronchitis	490.0	490.0

At the bottom of the window are buttons for Edit, New, Delete, Print Grid, and Close.

At this point you can review codes in the list or search for one you do not see. Clicking **New** (F8) or **Edit** (F9) opens up a window where you can create a new code or edit an existing one.

The 'Diagnosis: Arthritis-Hand' window displays the following fields and options:

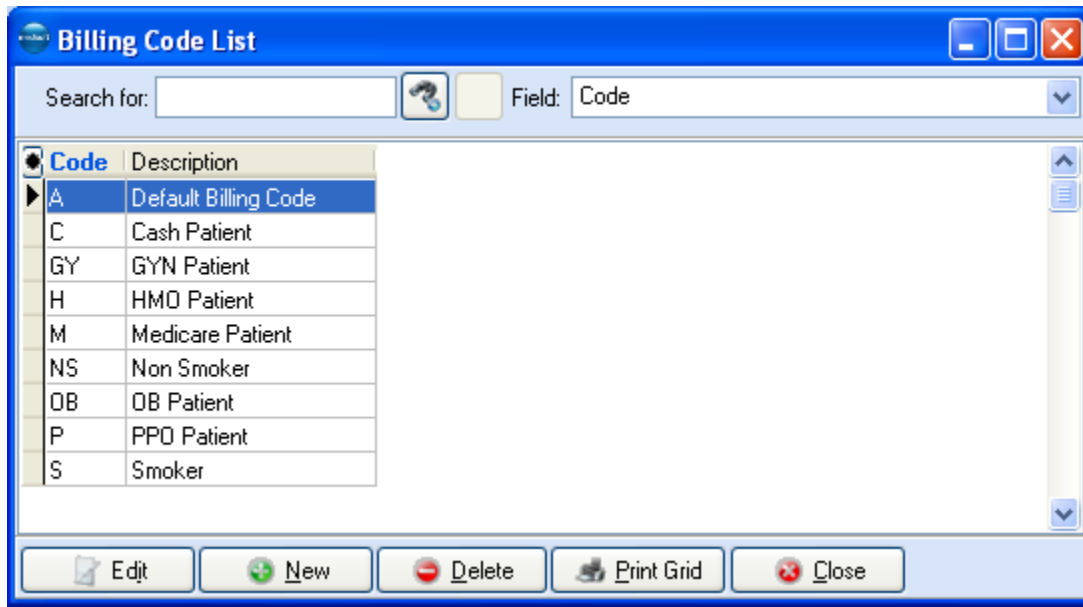
- Code 1: 716.94
- Description: Arthritis-Hand
- Alternate Code Sets section:
 - Code 2: 716.94
 - Code 3: 716.94
- ☐ HIPAA Approved
- Inactive Code ☐
- Buttons: Save, Cancel, Help

The **Diagnosis: (new)** window displays fields for the code number and description. You also have the option of entering **Alternate Code Sets**. These can be used later for entering codes for different carriers but for the same diagnosis.

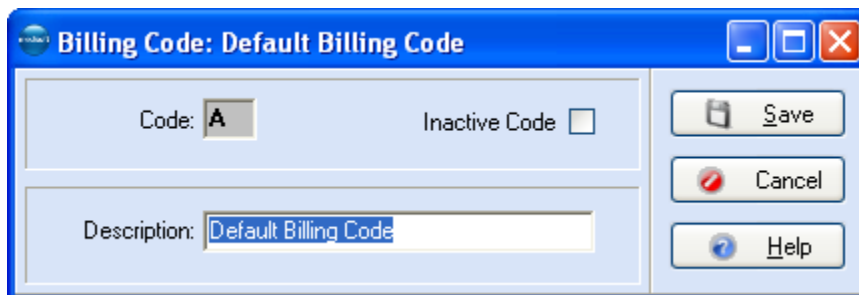
F1 Look up Diagnosis Entry

Billing Code List

A Billing Code is a user-defined two-character alphanumeric code. Billing Codes can be effective in sorting and grouping patient records. Go to the **Lists** menu and select **Billing Codes**.



The **Billing Code List** window lets you review and edit the codes contained in the program and create new ones. If you want to use a code you have not previously entered, click **New** or press **F8** and the window for a code and description appears.



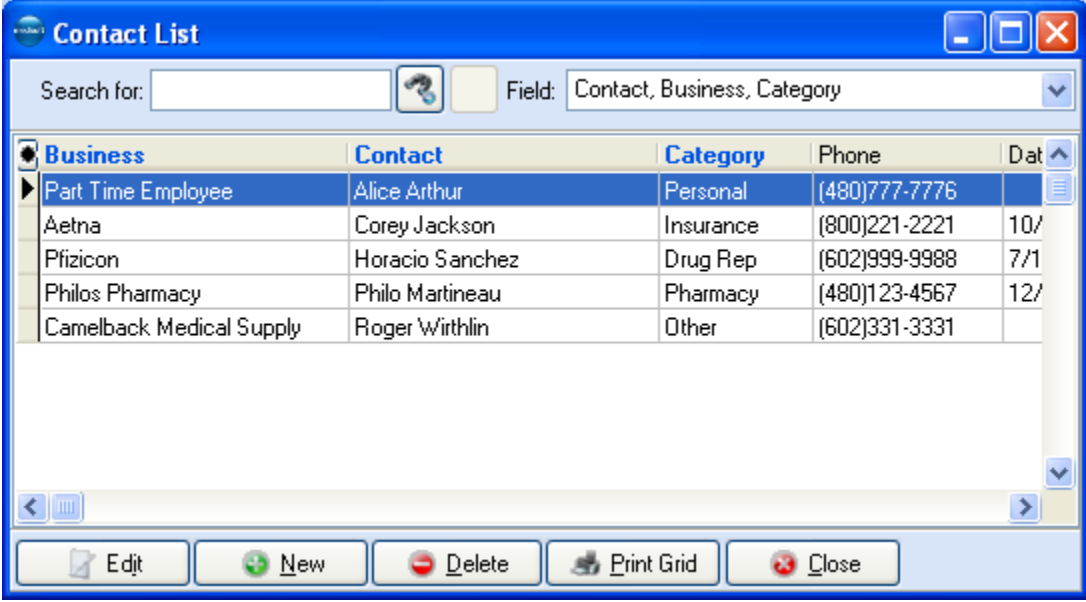
A billing code range is a filter available in most reports printed in Medisoft.

F1 Look up Billing Code Entry

Contact List

NOTE: This is an Advanced and above feature.

The **Contact List** contains a ready reference of people with whom you have had contact during the course of business. The **Contact** window has space where you can add notes concerning your conversations to help you keep track of what was discussed and any conclusions or information shared during the conversation. Click **Lists** and select **Contact List**.



Contact List

Search for: Field: Contact, Business, Category

Business	Contact	Category	Phone	Date
Part Time Employee	Alice Arthur	Personal	(480)777-7776	
Aetna	Corey Jackson	Insurance	(800)221-2221	10/
Pfizer	Horacio Sanchez	Drug Rep	(602)999-9988	7/1
Philos Pharmacy	Philo Martineau	Pharmacy	(480)123-4567	12/
Camelback Medical Supply	Roger Wirthlin	Other	(602)331-3331	

Buttons: Edit, New, Delete, Print Grid, Close

To create a new contact, click **New**; to edit an existing contact, click **Edit**.



Contact: Camelback Medical Supply - Roger Wirthlin

Category: Other

Business: Camelback Medical Supply

Name: Roger Wirthlin

Phone: (602)331-3331 Inactive ☐

Address: 99 E. Camelback Rd.

City: Scottsdale

State: AZ Zip: 85213

Date: Time:

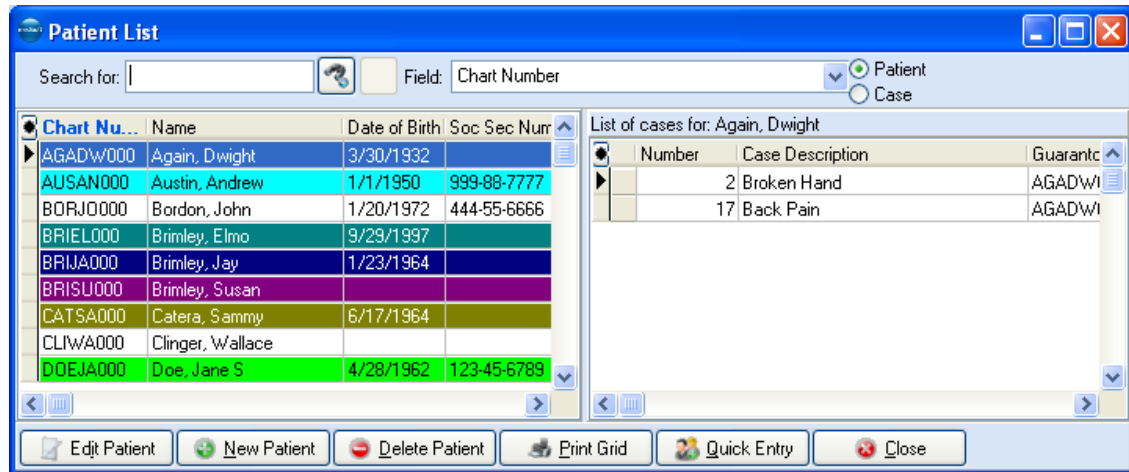
Notes: Roger is our contact for ordering supplies. You can also talk to his assistant Suzie.

Buttons: Save, Cancel, Help

For more information on the use of this feature, see:

F1 Look up Contact Entry**Setting Up Patient Records**

One of the most important functions in getting your practice computerized is entering patient data. Go to the **Lists** menu and select **Patients/Guarantors and Cases**.



You can search for an existing patient's record by entering the first few letters of his or her last name in the **Search for** field.

If you want the **Patient List** window to open automatically each time you open the program, go to **Program Options** and click **Patient List** in the **Show Windows on Startup** section of the General tab.

Clicking **New** or pressing **F8** opens an entry window to set up a new patient. Each of the data windows during setup lets you edit, change, or delete the information contained in window. The importance of entering correct information into the patient data files cannot be overemphasized. From setting up the chart numbers to entering percentage amounts for insurance claims, the effect of data entry is far reaching.

It is especially important to set up the guarantor when doing insurance billing.

F1 Look up Patient/Guarantor Entry**Setting Up the Chart Number**

Every patient or guarantor must have a chart number and be set up in the database before transactions can be entered.

If using the program's default automatic settings, each chart number consists of eight alphanumeric characters. If you leave the **Chart Number** field blank, the program automatically assigns a unique chart number. If you want, you can change the default settings and have the program automatically assign numeric chart numbers. Go to **Program Options**, open the **Data Entry** tab, and click **Use numeric chart numbers** in the **Patient** section.

If you want to establish your own patient chart numbering system, type a number or code as soon as you enter the new patient window. There is no need for corresponding numbers within a family; the number sequence has little bearing on grouping of patients. Each patient is set up individually in the program and individual bills are prepared for each guarantor. It is important to understand that once assigned, the Chart Number cannot be changed. To correct a wrong

chart number, you'd have to delete the entire patient record and create a new one with the proper chart number. All other data in the patient record can be modified.

F1 Look up Chart Number

New Patient Setup Window

Clicking **New Patient** or pressing **F8** lets you set up a new patient record in the program.

Enter all known or necessary information. When entering an address, the focus moves from the **Street** fields directly to the **Zip Code** field. The program has a feature that saves city, state, and zip code information in a table. Once you enter a zip code with its associated city and state, the next time you enter the zip code, the **City** and **State** fields are filled in automatically, saving you time when entering new records.

In the Medisoft Advanced and Medisoft Network Professional programs, you can establish default information, applied to all new patient records. Enter that information which is generally the same for all of your patients, and then click **Set Default**. To remove your new default settings, hold down **CTRL** and the button name changes to **Remove Default**.

When you enter a Social Security Number, the program checks through the patient records for any duplications. If a number you enter is a duplicate, the program displays the name and chart number of the patient first showing that Social Security Number.

Do not include spaces or hyphens as you enter dates or phone numbers. If you want the program to automatically hyphenate Social Security Numbers, go to **Program Options**, open the **Data Entry** tab, and click **Auto format Soc. Sec. #** in the **Patient** area. Then enter Social Security Numbers without hyphens.

The **Other Information** tab contains fields for additional information relevant to the patient record, such as the assigned provider, identification codes, and emergency contact numbers.

Patient / Guarantor: Bordon, John

Payment Plan: Custom

Name, Address: **Other Information**

Type: Patient

Assigned Provider: JM J.D. Mallard M.D.

Patient ID #2:

Patient Billing Code: M Medicare Patient

Patient Indicator:

Flag:

Healthcare ID:

☒ Signature On File Signature Date:

Emergency Contact

Name:

Home Phone: Cell Phone:

Default Employment Information for New Cases

Employer: BEA00 BeanSprout Express

Status: Unknown

Work Phone: (602)453-9988 Extension:

Location: Retirement Date:

Buttons: Save, Cancel, Help, Set Default, Copy Address..., Appointments

If you have chosen to use patient flagging (Advanced and above), the **Flag** field lets you choose which flag to associate with the patient record, including **None** if you want to disable the feature after assigning a flag.

F1 Look up Patient/Guarantor Entry-Other Information Tab

F1 Look up Program Options – Color Coding Tab (Advanced and above)

If the patient's employer record has been set up in the Address file, this data is available in the Other Information tab. Clicking the arrow or magnifying glass icon to the right of the **Employer**

field displays a list of those employer records already stored in the program. If the employer record you need is not available, press **F8** for the new employer setup.

Use the **Payment Plan** tab to assign a payment plan to a patient if the patient's account is in collection. Create patient payment plans by clicking **Lists** and selecting **Patient Payment Plan**.

F1 Look up Patient/Guarantor Entry - Payment Plan Tab

F1 Look up Patient Payment Plan Entry

Setting up a Case

Transactions within the program are generally case-based. A case is a grouping of procedures or transactions generally sharing a common treatment, facility or insurance carrier. You can set up as many new cases as needed.

Each new case that is set up needs to contain the patient's pertinent information. If you click **New Case** or press **F8** with the case list selected, only the Guarantor designation is copied to

the new case. To save time, click **Copy Case** to copy all the current case information, and then revise those portions of the data that are different for the new case.

You definitely want to open a new case if the treatment comes under a different insurance carrier. Suppose you are treating a diabetic patient regularly and he is injured on the job. His visits regarding the work-related injury should be kept in a Workers' Compensation case, totally separate from the regular visits, for legal and reporting reasons. The ideal situation is to have a case for each different malady from which the patient suffers. Then you can pull up groupings of case visits to help you evaluate the patient's overall health status. By pulling a case that contains all diabetic treatments, one for high blood pressure, one for angina, and one for cancer, you get a better picture of the full range of health problems.

TIP: If a patient comes for a onetime treatment, you can create a transaction for that treatment without creating an entirely new case. Just select different diagnosis codes in **Transaction Entry** when creating the transaction.

Existing case numbers are found in the **Patient List** window through which you set up new cases. Case numbers set by the program are sequential and not one of the numbers is repeated within the program in a single data set.

An existing case can be edited or reviewed through the **Patient List** window or accessed from any **Case** fields in the program by pressing **F9**. The patient **Case** window contains tabs that display fields necessary to complete an insurance claim form.

In Medisoft Advanced and Medisoft Network Professional, you can limit the tabs that are displayed. If a tab is not applicable to your practice or if you would prefer not to have it visible, right-click the tab. In the list that appears, click each tab you do not want displayed. That tab no longer appears in the **Case** window. To add tabs that are not visible, right-click the tabs and click the tab you want displayed to remove the check mark.

The Personal tab establishes the patient and his or her guarantor information, marital and student status, and employment.

Case: AGADW000 Again, Dwight [Broken Hand]

Miscellaneous | Medicaid and Tricare | Comment | EDI | Custom One | **Personal** | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | Condition

Case Number: 2 ☐ Case Closed

Description: Broken Hand ☐ Cash Case

Global Coverage Until: ☒ Print Patient Statement

Guarantor: AGADW000 Again, Dwight

Marital Status: Married Student Status: Non-student

Employment

Employer: REA00 Really Useful Trucking Co.

Status: Full time

Retirement Date: Work Phone: (602)457-3326

Location: Extension:

Patient Information

Name: Again, Dwight Home Phone: 434-5777

Address: 1742 N. 83rd Ave. Work Phone:

Phoenix, AZ Cell Phone:

85021 Date of Birth: 3/30/1932

Save Cancel Help

Eligibility... Face Sheet Set Default

Case 2

F1 Look up Case – Personal Tab

The Account tab displays the provider, referral, and attorney information set up in the Address file. It also covers billing and price codes and information on visit authorization, including the number of visits.

Case: AGADW000 Again, Dwight [Broken Hand]

Miscellaneous | Medicaid and Tricare | Comment | EDI | Custom One |
 Personal | **Account** | Diagnosis | Policy 1 | Policy 2 | Policy 3 | Condition

Assigned Provider: REL [v] [P] Robert E Lee M.D.
 Referring Provider: PIE00 [v] [P] Hawkeye Pierce M.D.
 Supervising Provider: [v] [P]
 Referral Source: [v] [P]
 Attorney: [v] [P]
 Facility: DES00 [v] [P] Desert Valley Hospital

Case Billing Code: M [v] [P] Medicare Patient
 Price Code: A Other Arrangements: Nsf2

Treatment Authorized Through: [v]

Visit Series
 Authorization Number: 6489211 Last Visit Date: 9/3/2002 [v]
 Authorized Number of Visits: 12 ID: A Last Visit Number: 1

Patient Information
 Name: Again, Dwight Home Phone: 434-5777
 Address: 1742 N. 83rd Ave. Work Phone:
 Phoenix, AZ Cell Phone:
 85021 Date of Birth: 3/30/1932

Save Cancel Help

Eligibility... Face Sheet Set Default

Case 2 [v] [P]

F1 Look up Case – Account Tab

The Diagnosis tab allows for entry of up to four default or permanent diagnosis codes for this case, plus entry for allergy and EDI notes. Information in the **Allergies and Notes** section is displayed in **Transaction Entry** and the **New Appointment Entry** window of Office Hours when a Chart number is selected.

Case: AGADW000 Again, Dwight [Broken Hand]

Miscellaneous | Medicaid and Tricare | Multimedia | Comment | EDI | Custom One

Personal | Account | **Diagnosis** | Policy 1 | Policy 2 | Policy 3 | Condition

Principal Diagnosis: 959.4 Injury, Hand POA ☐

Default Diagnosis 2:

Default Diagnosis 3:

Default Diagnosis 4:

Default Diagnosis 5:

Default Diagnosis 6:

Default Diagnosis 7:

Default Diagnosis 8:

Default Diagnosis 9:

Default Diagnosis 10:

Default Diagnosis 11:

Default Diagnosis 12:

EDI Report

Report Type Code: Report Transmission Code:

Attachment Control Number:

Patient Information

Name: Again, Dwight Home Phone: 434-5777

Address: 1742 N. 83rd Ave. Work Phone:

Phoenix, AZ Cell Phone:

85021 Date of Birth: 3/30/1932

Case 2

Save Cancel Help

UB04... Eligibility... Face Sheet Set Default

F1 Look up Case – Diagnosis Tab

The Condition tab allows for entry of information pertinent to the illness, pregnancy, or injury and tracking of symptoms. It also includes dates relative to the condition, plus Workers' Compensation information.

Case: AGADW000 Again, Dwight [Broken Hand]

Miscellaneous | Medicaid and Tricare | Multimedia | Comment | ED | Custom One

Personal | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | **Condition**

Injury/Illness/LMP Date: 2/27/2008 Date Similar Symptoms:

Illness Indicator: Injury

Initial Treatment Date:

☐ Same/Similar Symptoms
☐ Employment Related
☐ Emergency

Accident

Related To: Yes State:

Nature Of: Injured during Recreation

Last X-Ray Date: 3/1/1999

Death/Status

Dates

	From	To
Unable to Work:		
Total Disability:		
Partial Disability:		
Hospitalization:		

Workers' Compensation

Return To Work Indicator:

Percent of Disability:

Last Worked Date:

☐ Pregnant

Estimated Date of Birth:

Date Assumed Care:

Date Relinquished Care:

Condition Codes

1.	2.	3.	4.	5.	6.
7.	8.	9.	10.	11.	12.

Patient Information

Name: Again, Dwight Home Phone: 434-5777
Address: 1742 N. 83rd Ave. Work Phone:
Phoenix, AZ Cell Phone:
85021 Date of Birth: 3/30/1932

Save Cancel Help

Eligibility... Face Sheet Set Default

Case 2

F1 Look up Case – Condition Tab

The Miscellaneous tab contains supplemental information features like lab work charges, whether the lab is in-house or outside, **Referral** and **Prescription Dates**, **Local Use A** and **Local Use B** fields, case **Indicator** code, and prior authorization. It also provides space for recording information concerning a primary care provider outside your practice.

Case: AGADW000 Again, Dwight [Broken Hand]	
Personal Account Diagnosis Policy 1 Policy 2 Policy 3 Condition Miscellaneous Medicaid and Tricare Comment ED Custom One	Save Cancel Help Eligibility... Face Sheet Set Default
☐ Outside Lab Work Lab Charges: 0.00 Local Use A: HCFA box 10d Local Use B: HCFA box 19 Indicator: MEDICARE Referral Date: Prescription Date: Prior Authorization Number: HCFA box 23 Extra 1: Extra 2: Extra 3: Extra 4: Primary Care Provider Outside of This Practice Outside Primary Care Provider: Date Last Seen:	
Patient Information Name: Again, Dwight Address: 1742 N. 83rd Ave. Phoenix, AZ 85021 Home Phone: 434-5777 Work Phone: Cell Phone: Date of Birth: 3/30/1932	Case 2

F1 Look up Case – Miscellaneous Tab

The Policy 1, 2, and 3 tabs let you connect up to three insurance carriers to the patient record, including policy and group numbers, and **Insurance Coverage Percents by Service Classification** (how much the carrier pays for certain types of procedures). The service percentage classification is tied to each procedure code.

F1 Look up Procedure/Payment/Adjustment Entry

A **Deductible Met** check box is provided in the Policy 1 tab. When the patient meets his or her deductible obligation for the year, click this box and the status is displayed in the patient account detail of the **Transaction Entry** window.

The three tabs have the same layout, except Policy 1 asks about **Capitated Plan** and **Co-Pay Amount** and has the **Deductible Met** check box; Policy 2 asks if this is a **Crossover Plan**; and Policy 3 can be set up for tertiary or third-party involvement.

Case: AGADW000 Again, Dwight [Back Pain]

Miscellaneous | Medicaid and Tricare | Multimedia | Comment | EDI | Custom One

Personal | Account | Diagnosis | **Policy 1** | Policy 2 | Policy 3 | Condition

Insurance 1: MED01 Medicare

Policy Holder 1: AGADW000 Again, Dwight

Relationship to Insured: Self

Policy Number: 780340761

Group Number: 23c

Group Name:

Claim Number:

Policy Dates

Start:

End:

☒ Assignment of Benefits/Accept Assignment

☐ Capitated Plan

Deductible Met: ☐

Annual Deductible: 0.00

Copayment Amount: 20.00

Treatment Authorization:

Document Control Number:

Insurance Coverage Percents by Service Classification

A:	80	C:	0	E:	80	G:	80
B:	100	D:	80	F:	80	H:	80

Patient Information

Name: Again, Dwight

Address: 1742 N. 83rd Ave.
Phoenix, AZ
85021

Home Phone: 434-5777

Work Phone:

Cell Phone:

Date of Birth: 3/30/1932

Save

Cancel

Help

UB04...

Eligibility...

Face Sheet

Set Default

Case 17

F1 Look up Case – Policy 1, 2, and 3 Tabs

The Medicaid and TRICARE tab includes fields for all submission numbers, reference, and data for each carrier. It also includes branch of service information.

Within the Medicaid and Tricare tab are **EPSDT** and **Family Planning** indicators, required submission numbers, and reference data for the case. It also includes service information for TRICARE claims.

Case: AGADW000 Again, Dwight [Back Pain]

Personal | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | Condition | Miscellaneous | **Medicaid and Tricare** | Multimedia | Comment | EDI | Custom One

Medicaid

☐ EPSDT Resubmission Number:

☐ Family Planning Original Reference:

Service Authorization Exception Code:

Special Program Code:

EPSDT Referral Code:

Tricare/Champus

Non-Availability Indicator:

Branch of Service:

Sponsor Status:

Special Program:

Sponsor Grade:

Effective Dates

Start:

End:

Patient Information

Name: Again, Dwight Home Phone: 434-5777

Address: 1742 N. 83rd Ave. Work Phone:

Phoenix, AZ Cell Phone:

85021 Date of Birth: 3/30/1932

Case: 17

Save | Cancel | Help | Eligibility... | Face Sheet | Set Default

F1 Look up Case – Medicaid and Tricare Tab

The Multimedia tab (Network Professional only) allows you to add bitmaps, video, or sound to your patient records.

F1 Look up Case – Multimedia Tab and Multimedia Entry

The Comment tab (Advanced and above) is provided for the entry of notes to be printed on statements.

Case: AGADW000 Again, Dwight [Broken Hand]

Personal | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | Condition | Miscellaneous | Medicaid and Tricare | Multimedia | **Comment** | EDI | Custom One

Allergies and Notes

Contract Information

Contract Type Code: Contract Amount:
Contract Percent: Contract Code:
Terms Discount Percent: Contract Version:

Comment

Patient Information

Name: Again, Dwight Home Phone: 434-5777
Address: 1742 N. 83rd Ave. Work Phone:
Phoenix, AZ Cell Phone:
85021 Date of Birth: 3/30/1932

Save Cancel Help UB04... Eligibility... Face Sheet Set Default

Case 2

F1 Look up Case – Comment Tab

This EDI tab is where you enter information for electronic claims specific to this case. If applicable to the claims for this case, enter values in the fields.

Case: AGADW000 Again, Dwight [Broken Hand]

Personal | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | Condition | Miscellaneous | Medicaid and Tricare | Multimedia | Comment | **EDI** | Custom One

Care Plan Oversight #: Assignment Indicator:

Hospice Number: Timely Filing Indicator:

CLIA Number: Homebound: ☐

Mammography Certification:

Referral Access #:

Demo Code:

IDE Number:

Vision Claims

Condition Indicator: Code Category:

Certification Code Applies: ☐

Home Health Claims

Total Visits Rendered: Discipline Type Code:

Total Visits Projected: Ship/Delivery Pattern Code:

Number of Visits: Ship/Delivery Time Code:

Duration: Frequency Period:

Number of Units: Frequency Count:

Patient Information

Name: Again, Dwight Home Phone: 434-5777

Address: 1742 N. 83rd Ave. Work Phone:

Phoenix, AZ Cell Phone:

85021 Date of Birth: 3/30/1932

Save Cancel Help

Eligibility... Face Sheet Set Default

Case 2

F1 Look up Case – EDI Tab

Default Printer Selection

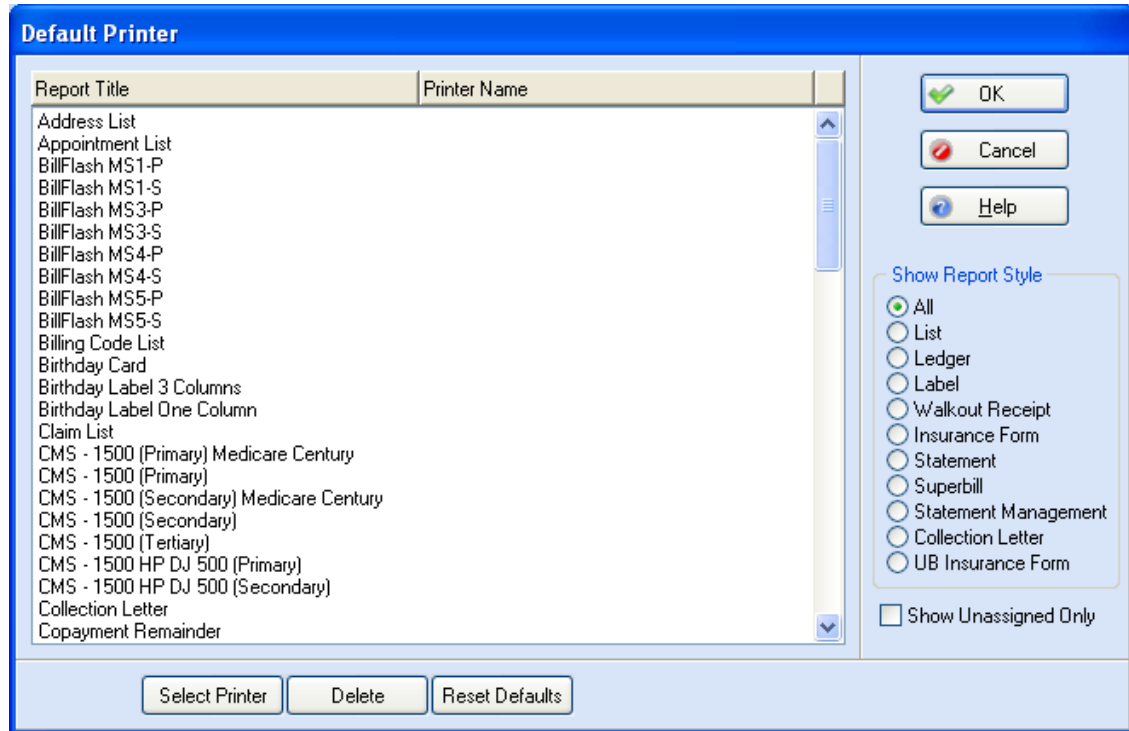
NOTE: This is an Advanced and above feature.

Setting a default printer for printing various superbills, claims, and statements involves a series of simple steps to first identify items to be assigned to a specific device, followed by any additional print setup selections.

Open Medisoft and select the **Default Printer Options** command from the **Reports** menu window. The Default Printer window will open.

NOTE: this command is only available by default, if security is applied, to level 1 users. If you plan on other user levels having access you will need to change the default

permissions in the Permissions window. If you are not using security any default printer settings are saved to the workstation.



You will use the Default Printer Window to assign a printer to superbills, claims, and statements. The window displays available reports and provides controls to select or delete a default printer. After selecting a report, you can click the Select Printer button to select a printer from the Print window. On the Print window (standard Windows printer interface window), you can further select other available settings. You can also select multiple reports to assign to a default printer by holding down the CTRL Key while clicking a report at the start of the range and holding down the CTRL Key while clicking a report at the end of the list. Then when you click the Select Printer button, you can assign all the selected items to the same default printer using the same default settings.

The window also features a Delete button to remove a default printer from a report and a Reset Default button to remove all assigned printers from the available reports.

If you assign a default printer to a report and the printer is not available for printing (disconnected from the network, off-line, etc.), the system will prompt you to select another printer or cancel the print job. If the printer is permanently no longer available, you would need to assign another printer to all reports that were using this resource.

F1 Default Printer Setup Options

F1 Setting a Default Printer

Entering Transactions

Transaction Entry Overview

The **Transaction Entry** window is designed for easy transaction entry and to display as much information with as few clicks or keystrokes as possible. Not only do you record all patient visits and their charges, you also enter payments and adjustments that may be added to the ledger.

Medisoft is an Open Item Accounting program, meaning that transactions entered are marked when paid but remain on the active ledger as long as the case is active. There is no clearing of the ledger and bringing up a total to start a new month, as with a balance forward program.

Transaction entry is generally case-based. Transactions are entered into the patient ledger grouped by case number. You can have a case for each transaction or for each diagnosis type.

F1 Look up Transaction Entry

Start with a Chart Number

From the **Activities** menu select **Enter Transactions** or click the Transaction Entry speed button. Within **Transaction Entry**, two numbers are of prime importance: the chart number and the case number.

Enter the chart number or click the **Chart** field and select the chart number from the drop-down list. You also have the option of entering the superbill number or selecting the superbill number from the drop-down list in the **Superbill** field. If the patient record has not yet been set up, press **F8** to bring up the **Patient/Guarantor: (new)** window. See Setting up Patient Records for more information.

When you press **TAB** or **ENTER**, a case number is selected in the **Case** field (if one is available). By default, the most recently opened case is opened. You can change the default in the **Program Options** window, Data Entry tab, **Case Default** field, see Data Entry Tab .

If you want to create a new case, the shortcut to bring up the **Case** window is **F8**. Another method of selecting a specific case is to click the speed button to the right of the **Case** description field to open the **Select Case by Transaction Date** window. Cases are sorted on the Case drop-down menu based on the case number and appear in descending order; for instance, case nine would appear at the top of the list, followed by case five, followed by case four, etc.

F1 Look up Select Case by Transaction Date

A document number is automatically assigned by the program and is used for reference and filtering purposes, whether the field is displayed in the **Transaction Entry** window or not. You can replace this number with your own if you want.

If you use superbills, you can enter a superbill Serial Number in this field to help keep track of the superbill. To use superbill numbers in **Transaction Entry**, open **Program Options** and click both **Force Document Number** and **Use Serialized Superbills** in the Data Entry tab.

You can also print blank, serialized superbills that are not assigned to an appointment. Before using the feature if you have security applied to your practice, you will need to give access to this feature to appropriate users. The default setting is for level 1 users only. For information on changing permissions, see Setting Permissions.

F1 Look up Permissions

The same options you selected to use Superbills also applies if you want to print blank superbills: the Force Document Number and Use Serialized Superbills options on the Program Options window, Data tab must be selected.

Once enabled, you can print a blank Superbill by selecting the Blank Superbill command on the Reports menu and at a later date, assign the blank superbill to a chart and case in the Transaction Entry.

F1 Look up Printing Blank Superbills

F1 Assigning a Blank Superbill to a Patient and a Case

Sometimes there is a need to provide more documentation about a transaction. This can be done in a special **Transaction Documentation** window activated by pressing **F5** or clicking **Note** in the **Charges** section of the **Transaction Entry** window.

There are various transaction documentation types available, and they can be viewed in the **Quick Ledger**.

F1 Look up Transaction Documentation

If you need to enter drug/prescription information for a charge on the Transaction Entry window, you can click the Details button to open the Transaction Details window. On this window you can add data which is then included on a custom report or a printed claim. You will need to customize a report and modify fields 24A-24H to add National Drug Code (NDC) data in a charge line (electronic claims automatically pulls this data for claims). For more information on modifying a report, see Report Designer. And, to view NDC Information on the Transaction Entry, you will need to add the NDC fields to the grid.

F1 Look up Adding NDC Information, Report Designer, and Grid Columns

Entering a Charge in Transaction Entry

Once you have selected patient chart and case number in the **Transaction Entry** window, click **New** or click in any column of the **Charges** section.

The current date is automatically entered. If you are entering transactions from earlier dates, insert the correct date of the entries with which you are working. If you have a number of transactions from a different date, you can change the program date by clicking the date in the lower right corner of the program window and selecting a new date. Be sure to change the date back to the current date when finished.

The Transaction Entry window displays on a tabbed panel the current insurance carriers assigned to the patient's case along with the aging columns. The aging columns' appearance is dictated by setting on the Program Options tab.

Enter information in the **Procedure** column and any other information that is necessary to complete this charge transaction.

To create a second charge transaction, click the down arrow key or click **New**.

Sort the columns in the Transaction entry by clicking a column header to sort the grid by that value (Medisoft Advanced and Medisoft Network Professional feature). For instance, click the Procedure header to display transactions sorted by the procedure numbers of the line items. The default sorting pattern is based on date and sorts in a descending order and the last sort selection is also saved for next use. For more information, see:

F1 Look up Sorting the Transaction Entry Grids

Entering a Payment or Adjustment in Transaction Entry

After selecting patient chart and case numbers in the **Transaction Entry** window, you can enter a payment by clicking **New** in the **Payments, Adjustments, and Comments** section of the window.

The current date is inserted in the **Date** field. Select the **Pay/Adj Code**, and then enter **Who Paid**, a **Description**, and the **Amount**. If the payment is being made by check, the check number can be entered in the **Description** field.

Apply Payments or Adjustments to Charges

WARNING: We recommend that you apply all payments and adjustments to charges. Failure to do so results in other parts of the program not functioning properly, i.e.,

remainder billing and the delay secondary billing feature (Advanced and above), to name only two. In addition, some report results will be incomplete or inaccurate.

You can distribute a payment or an adjustment to a specific charge or charges by clicking **Apply**. The **Apply Payment to Charges** or **Apply Adjustment to Charges** window opens (depending on whether you are applying a charge or an adjustment) and lets you direct that payment or adjustment to the proper charge or charges.

Besides displaying the source of the payment or adjustment and the patient's name, the **Apply Payment to Charges** or **Apply Adjustment to Charges** window also displays the number of charges in this case. The upper right corner displays the unapplied amount entered in the payment.

Once the entry is complete and verified, click **Close** to return to **Transaction Entry**. You can then click **Print Receipt** (which gives the patient a Walkout Receipt before leaving the office), click **Print Claim** (which prepares entries that have not yet been submitted on an insurance claim and sends them to print), or click **Close** to exit the window.

F1 Look up Apply Payment to Charges or Apply Adjustment to Charges

Unprocessed Transactions

The **Unprocessed Charges** window provides an interface between an Electronic Medical Records (EMR) service and Medisoft via Communications Manager.

This window provides controls to edit and post financial transactions imported from an EMR service to Medisoft.

Transactions imported into Medisoft from an EMR service through **Communications Manager** are held as Unprocessed Charges until they can be processed by a Medisoft user.

From the **Activities** menu, select **Unprocessed Transaction** and then select **Unprocessed EMR Charges**. The **Unprocessed Charges** window appears with a list of transactions that have yet to be posted.

The columns in the list correspond to information from the EMR application. Columns such as billing, providers, diagnosis codes, and procedure codes should be reflected in the same manner as found in your practice management software.

Unprocessed Charges						
ID	Post	Transaction Status	Chart_Number	Case	Provider	Date_From
696c996c837d4001897e520e5fa0721b	☐	✗	PALTI000	-1	JM	3/9/2007 8:47:00 AM
a0017a9ebe2646bcbcd67c1305705621	☐	✗	JACTH000	-1	JM	3/9/2007 8:56:00 AM
432a970191cc4c8dae7602f8fd521786	☐	✓	AGADw000	17	JM	3/9/2007 8:58:00 AM
440a606fea254fdeabe8456d1c2d7f5a	☐	✓	PETMO000	18	JM	3/9/2007 8:59:00 AM
d67ed966ea254a6b95e5fb2ec03eb9ae	☐	✓	BRIJA000	3	JM	3/9/2007 9:01:00 AM
5c168f98729d409b8c2bb2a82e7df4dc	☐	✓	BRIJA000	3	JM	3/9/2007 9:01:00 AM
2c2bf9c5deca44a7b03070b974926ec3	☐	✓	BRIJA000	3	JM	3/9/2007 9:01:00 AM

F1 Unprocessed Transactions Overview

Communications Manager Overview

This product allows you to transfer data between Medisoft and EMR programs. Currently, you can create a connection to Medisoft Clinical, InstantDx, Practice Partner Patient Records, MediNotes, RelayHealth (send patient demographics only), and SpringCharts. The product also provides a Standard HL7 connection type that supports sending patient demographics and scheduling data to any EMR that is HL7 and Communications Manager compliant.

There are two major components to the Communications Manager suite:

Communications Manager: This portion of the program allows you to create connections between your practice management software and EMR programs. One connection to an EMR program can be created for each practice. Communications Manager also allows you to define connection settings and manage connection errors. Once you set up your connections, it rarely requires additional maintenance.

Communications Messenger: This portion of the program manages the transfer of data between your practice management software and EMR programs. Once you have enabled the Communications Messenger and set up your connections through Communications Manager, Communications Messenger will automatically deliver and receive data. Once this program successfully sends its first message, it rarely requires additional maintenance.

For more information, see:

F1 Look up Communications Manager Main Window

F1 Look up Creating a New Connection

Patient Treatment Plans

NOTE: This is a Network Professional only feature.

When a patient has a choice of options for the treatment he or she can receive, a treatment plan can be prepared which sets out the different treatments offered and the cost of each plan.

F1 Look up Treatment Plan List

Print Receipts, Create Claims

Once a transaction has been entered and saved, the transaction can be displayed in the **Transaction Entry** window. By sliding the scroll bar at the bottom of the window, a full summary of the transaction is revealed.

You can now print a receipt for the patient, file a claim, or close the window.

F1 Look up Create Claims

Billing Charges

NOTE: This is an Advanced and above feature.

This feature lets you apply billing charges to accounts that are past due.

Before you can use this feature, you must set up at least one billing charge type of procedure code. Do this through the **Procedure/Payment/Adjustment List** and **Procedure/Payment/Adjustment: (new)** windows. Fill in the **Code 1** and **Description** fields. Be sure to select **Billing charge** in the **Code Type** field. Add whatever other information you want and save the code. Create as many billing charge codes as you need.

If desired, you can use billing codes (which are used to categorize patient records) and indicator codes in applying billing charges. Be sure these codes are set up if you want to use them.

Go to the **Activities** menu and select **Billing Charges**.

Billing Charges

NOTE: Be sure to back up your data before proceeding!

Chart Number Range: to

Billing Codes Range: to

Case Indicator Match:

A blank field indicates no limitation, all records will be included.

Charges Creation Date:

Transaction charges days old.

Monthly Billing Charge %:

Billing Charge Procedure:

Minimum Past Due Balance:

Minimum Billing Charge:

Maximum Billing Charge:

☒ Check this box if you want to exclude a case that has had a payment made after or during the past due period.

Use the range limitations to select the records to which you want to apply the billing charges. The **Charges Creation Date** is the date that appears in the ledger with the billing charges. This can be whatever date you choose (but the transactions created still show on the current day's activity reports).

Fill out all the requested information, then click **Start**. New transactions are added to each patient record that fits the criteria you selected.

F1 Look up Billing Charges and Procedure/Payment/Adjustment Entry

Quick Ledger

NOTE: This is an Advanced and above feature.

The **Quick Ledger** in Medisoft gives a quick reference for transaction and other information in the patient's account. There are two types of Quick Ledgers in Medisoft: the **Patient Ledger** and the **Guarantor Ledger**.

The **Patient Ledger** displays transaction information and account totals for individual patients. The Patient Ledger is the default ledger in Medisoft.

Quick Ledger

Chart: AGADW000 **Again, Dwight** Account Alert RB OC ☐ View Open Items Only
Global Coverage Until:

Birthdate: 3/30/1932 [Note] [Edit] [Charge Detail] [Filter] Sort By: Case Number [Previous] [Next]

Date From	Document	Description	Provider	Procedure	Case	Units	Amount	Stmnt #	Statement	Claim	Bill 1
9/3/2002	0209030000		REL	73130	2	1	45.00	9		7	Yes
9/3/2002	0209030000		REL	99213	2	1	60.00	9		7	Yes
12/6/2002	0209030000	Carrier: MED01 was billed	REL	COMMENT	2	1	0.00	0		7	No
11/21/2002	0211210000		REL	99213	17	1	60.00	9		2	Yes
11/21/2002	0211210000		REL	72052	17	1	80.00	9		2	Yes
11/21/2002	0211210000		REL	97010	17	1	10.00	9		2	Yes
11/21/2002	0211210000	Carrier: MED01 was billed	REL	COMMENT	17	1	0.00	0		2	No
12/4/2002	0211210000	#23664	REL	MP	17	1	-48.00	0		0	No
12/4/2002	0211210000	#23664	REL	MP	17	1	-63.00	0		0	No
12/4/2002	0211210000	#23664	REL	MP	17	1	-8.00	0		0	No
12/4/2002	0211210000	Carrier: AET00 was billed	REL	COMMENT	17	1	0.00	0		2	No
3/9/2007	0703090000		REL	99213	17	1	60.00	0		0	No

Account Total: 196.00 [Print] [Quick Statement] [Statement] [Close]

The **Guarantor Ledger** provides the same information as the Patient Ledger but allows you to view guarantor totals as well. In the **Program Options, General** tab, you can select Guarantor Ledger as your default ledger.

Guarantor Ledger

Guarantor: BORJ0000 **Bordon, John** Account Alert RB Family Total: 106.00

Chart: BORJ0000 **Bordon, John** Account Alert RB ☐ View Open Items Only
Global Coverage Until:

Birthdate: 1/20/1972 [Note] [Edit] [Payment Detail] [Filter] Sort By: Case Number [Previous] [Next]

Date From	Document	Description	Provider	Procedure	Case	Units	Amount	Stmnt #	Statement	Claim	Bill 1
2/9/2006	0602090000		JM	99214	16	1	65.00	0		0	No
2/9/2006	0602090000		JM	82947	16	1	25.00	0		0	No
2/9/2006	0602090000		JM	36215	16	1	8.00	0		0	No
2/9/2006	0602090000		JM	99000	16	1	8.00	0		0	No

Account Total: 106.00 Remainder: 8.00 [Print] [Quick Statement] [Statement] [Close]

To get quick and easy access to a patient's ledger from almost anywhere in the program, press **F7** or click the Quick Ledger speed button.

While no new transactions can be made in the ledger itself, it is possible to edit and print the ledger and gain valuable detail on patient accounts.

You can change responsibility for a selected transaction in the **Quick Ledger** window. Right-click a transaction to change its responsibility between insurance carriers or from an insurance

to the patient. This feature lets you skip entering the zero-dollar insurance payment to indicate that no payment is coming from the insurance carrier.

F1 Look up Changing Responsibility in Quick Ledger

The **Quick Ledger** detail window is very similar to the **Transaction Entry** window. Use the horizontal scroll bar to reveal additional data fields. A navigation bar lets you move quickly through the list of transactions. Three buttons open additional data fields.

Click **Edit** or press **F9** to open the **Transaction Entry** window where charges, payments and adjustments can be reviewed and edited, as needed. Both the Patient and the Guarantor Ledgers let you view the notes entered for transactions in the grid and also add a note. Click the Note button or press F5 to toggle the display any transaction notes attached to the transaction. If a note is not yet attached, you can enter a note. The second column from the left (next to the record pointer column) displays a note icon if the transaction has a note.

F1 Adding a Note to a Line Item on the Quick Ledger

Click **Payment Detail** to display all payments/adjustments made toward a specific charge. Click **Filter** to search which transaction data to display. Real power comes with using multiple filters. Navigation buttons in the **Payment/Adjustment Detail** window are for selecting other entries in the **Quick Ledger** to review without having to exit the **Payment/Adjustment Detail** window first.

TIP: If you click **Quick Statement**, you print statements from the **Reports** menu. If you click **Statement**, you print statements from **Statement Management**.

F1 Look up Quick Ledger, Payment/Adjustment Detail, and Transaction Filter

Quick Balance

NOTE: This is an Advanced and above feature.

Quick Balance is a quick summary of all remainder charge totals contained within the program for a selected guarantor record. Click **Activities** and select **Quick Balance** or press **F11** to access the feature.

The screenshot shows a window titled "Quick Balance" with a blue header bar. Below the header, there is a "Chart:" label followed by a dropdown menu showing "AGADW000" and a search icon. To the right of the dropdown is a yellow highlighted area containing the text "Again, Dwight". Below this is a table with three columns: "Chart Number", "Patient Name", and "Amount". The table contains one row with the values "AGADW000", "Again, Dwight", and "0.00". At the bottom of the window, there is a label "Guarantor Remainder Total: \$" followed by a text box containing "0.00". To the right of the text box are two buttons: "Print" and "Close".

Chart Number	Patient Name	Amount
AGADW000	Again, Dwight	0.00

Guarantor Remainder Total: \$ 0.00

Print Close

If the record selected is a guarantor's record, the **Quick Balance** window displays each patient for whom the guarantor is responsible and the total qualifying remainder charges for each. If the record selected is not a guarantor's record, a listing of all the selected patient's guarantors is displayed. Choose a guarantor to see the quick balance.

TIP: If you click **Print** in **Quick Balance**, you print statements from the **Reports** menu.

F1 Look up Quick Balance

Creating Claims

Claim Management

This section explains briefly how to manage claims within the **Claim Management** window and includes creating, editing, printing/reprinting, and listing claims, as well as changing claim status.

The Claim Manager's Job

To help you better understand the function of claim management, let's use a shipping analogy. Whereas Cases are containers filled with claims for specific diagnoses, claim management is the process by which the cases are checked, sorted and delivered. In other words, claim management is the process of making sure all shipments are correct, ready to be sent and shipped to the right companies (insurance carriers).

The Claim Manager (the person performing claim management) checks the claims, makes sure the boxes are properly marked, and sends them on their way. She determines whether the shipment goes by truck (paper claims) or by air (electronic claims). When a box is returned (rejected claim), the Claim Manager makes whatever changes are necessary (with help from the EOB or Audit/Edit Report) and ships the box again (resubmits the claim).

Someone else sees and treats the patients. Another person enters data from the superbill to begin the billing process. Once all the data has been entered, it must go through the Claim Manager's office before being sent to an insurance carrier.

The Claim Manager focuses on three principal areas, not necessarily sequential: review, batch, and final review.

Watchdog: The Claim Manager is, first of all, the watchdog of the claims. She checks each claim and verifies the numbers. She has the authority to edit the claim and make needed changes. If she sees that a claim should go to a different carrier than indicated, or if the EDI receiver information is incomplete, she corrects the record. She also has access to the insurance carrier records. She checks the billing date and how the claim is to be sent, either by paper or electronically. And then she can indicate the status of the claim. There is a place where she can add any special instructions that need to go with the claim.

Batch 'em up! The function of creating claims serves to group claims that are headed to the same destination. The Claim Manager gathers and sorts by range of dates or chart numbers. Transactions can be selected that match by primary carrier, Billing Code, case indicator, or location. Random Billing Code numbers can be selected. The Claim Manager can also indicate a minimum dollar amount for creating the claims, eliminating claims too small to be worth billing.

Reviewer: The Claim Manager has at her fingertips a **List Only** button that lets her retrieve claims that match a certain criteria that she has determined. The **List Only Claims That Match** window is a "show me" window that lets the Claim Manager review all that is in the program. The claims that come before her can be given a final check for accuracy and completeness. She can select specific or all carriers to review. She can group all electronic media claims.

Besides these three focus areas, the Claim Manager also has responsibility to mark claims that are paid and those that are rejected.

Marking paid claims: The date of submission in the **Claim Management** window indicates when the claims were shipped or transmitted. Claims are marked under the designation of "Sent" and the date is automatically inserted. The claims stay in **Claim Management** marked as "Sent" until they are manually changed in the **Claim** edit window as having been received

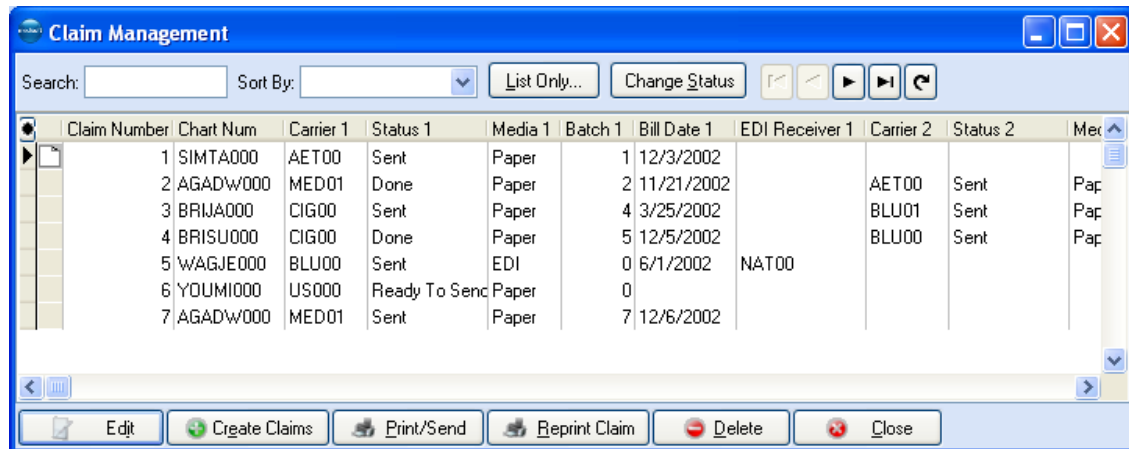
and dispatched by the carrier. When a payment is received, use the EOB to enter all payments through transaction entry. If selected in **Program Options** (Payment Application tab, **Mark Completed Claims Done** field), the status for paid claims is automatically changed to "Done."

Handling rejected claims: When a paper claim is rejected for payment by the insurance carrier, change the payment status in the **Claim Management** window from "Sent" to "Rejected."

Now put yourself in the picture. Picture yourself as the Claim Manager. The tools by which you get the job done are found in **Claim Management**.

The Claim Management Window

To perform any claim management functions, go to the **Activities** menu and select **Claim Management**, or click the Claim Management speed button. This window features several sections used for various tasks.



Header

Search: Enter values for which you want to search in the grid. This field is affected by the variable in the Sort By field

Sort By: Click the down arrow to select the variable by which you want to search. For more information, see:

F1 Look up Grid Columns

List Only: Click this button to list only certain claims in the grid. For more information, see:

F1 Look up List Only Claims that Match

Change Status: Click this button to change the status on a batch of claims. For more information, see:

F1 Look up Change Claim Status/Billing Method

Navigation Buttons: These buttons in the upper right corner of the window allow you to move through the displayed records. The button at the right end of the navigation buttons refreshes the information in the grid.

Grid

This section shows you information about each claim. You can add and remove fields from this section by clicking the grid modification button in the top left corner of the grid.

F1 Look up Grid Columns

Click a column header to sort the grid by that column. When you exit the Claim Management window, the application saves your currently selected sorting pattern and displays this selection the next time you access the window.

The column next to the record pointer indicates whether notes are attached to the particular claim. If the column contains a page icon, highlight the record and press F5 to view the note.

F1 Look up Claim Comment

Buttons

Edit: Click this button to edit the selected claim.

F1 Look up Edit Claim

Create Claims: Click this button to create claims.

F1 Look up Create Claims

Print/Send: Click this button to print the claims on paper or send them electronically.

F1 Look up Print/Send Claims

Reprint Claim: Click this button to rebill claims.

F1 Look up Reprinting Claims.

Delete: Click this button to delete the claim number and release the transactions bound to the claim. You can then put those transactions on a different claim.

Close: Click this button to close the window.

Creating Claims

It is in the creating claims operation that a claim is finally prepared for submission.

Preparation can involve a single claim or a batch. Claims are gathered by range of dates and/or chart numbers. The selection of claims to be created can be further narrowed by specifying detail in the **Select transactions that match**, **Provider**, and **Include transactions if the sum is greater than** fields.

Create Claims

Range of

Transaction Dates: [dropdown] to [dropdown]

Chart Numbers: [dropdown] to [dropdown]

Select transactions that match:

Primary Insurance: [text field]

Billing Codes: [text field]

Case Indicator: [text field]

Location: [text field]

Provider

☒ Assigned [text field]

☐ Attending

Include transactions if the claim total is greater than:

Enter Amount: [text field]

Create

Cancel

Help

F1 Look up Create Claims

Editing Claims

This function within the program is the watch dog area where you can verify and edit the claims that are ready to be submitted for payment. It is a safety net where problems can be solved, and information entered in a transaction can be overridden if necessary. An override in the **Claim** edit window changes that claim submission, but does not affect the default database.

As the claim comes up for final verification, it may be determined that a change needs to be made, such as a different carrier or EDI receiver.

By highlighting a specific claim and clicking **Edit** or pressing **F9**, the **Claim** edit window appears with the claim details and information concerning all assigned insurance carriers and their pertinent data.

The detail also indicates submission method assigned to the claim (paper or electronic), as well as the claim status. Claim status options include: **Hold**, **Ready to send**, **Sent**, **Rejected**, **Challenge**, **Alert**, **Done**, or **Pending**. The status of the claim can be changed at this point.

Any time a claim is sent, a batch number is assigned. That number shows in the **Batch** data box in the center of the window of the claim you are reviewing. If a claim needs to be resubmitted, the batch number coincides with the number shown in the **Claim Management** window and the one you use to designate those claims that need to be resubmitted.

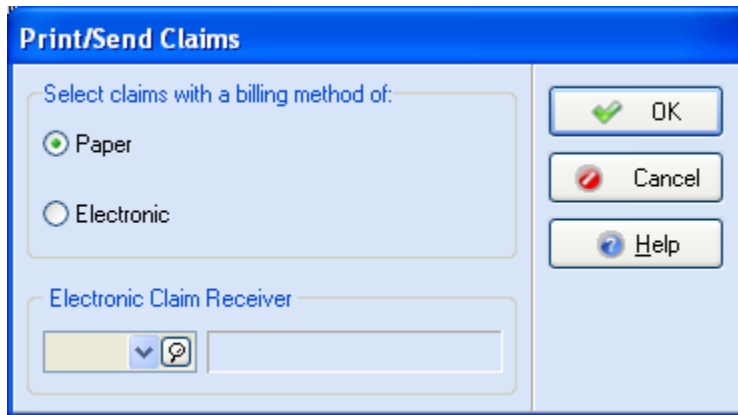
The Transactions tab reveals a listing of all transactions applied to the selected claim. You can split, add, or remove qualifying transactions in this tab. The Comment tab provides an empty box in which to place whatever comments you feel are necessary concerning this claim and/or any transactions relating to it. If you have Medisoft Advanced or Medisoft Network Professional, these notes are represented by a note icon in the **Claim Management** window. Double-click the icon to view or edit the note.

F1 Look up Edit Claim

Printing Claims

Once claims are created, you can print them by clicking **Print/Send**. Indicate whether you are sending the claims on paper or electronically, then apply filters to select only those claims you want to send.

F1 Look up Print/Send Claims



Troubleshooting Insurance Claims

Claim Form Not Centered

If your insurance claims are printing just a little off center, this can be fixed by entering the Report Designer (**Reports** menu, **Design Custom Reports and Bills**). Open the insurance form you use for printing claims. Go to the **File** menu and select **Report Properties**. In the **Form Offset** area of the window, adjust the form as necessary from the top and/or left margins. The form is moved in increments of one hundredth of an inch. When the form is adjusted, save the form, exit the Report Designer, and reprint your claim.

F1 Look up Report Designer

Reprinting Claims

If necessary, you can reprint claims without regard to their status. To reprint an entire batch, the status must be changed for the batch.

F1 Look up Reprinting Claims

Listing Claims

The **Claim Management** window has a claims viewing feature that lets you retrieve claims that match a set of criteria that you define. Click **List Only**.

List Only Claims That Match

Chart Number:

Claim Created:

Select claims for only

☒ All ☐ Primary ☐ Secondary ☐ Tertiary

That match one or more of these criteria:

Insurance Carrier:

EDI Receiver:

Billing Method

☒ All ☐ Paper ☐ Electronic

Claim Status

☒ All ☐ Hold ☐ Ready to Send ☐ Sent ☐ Rejected ☐ Challenge ☐ Alert ☐ Done ☒ Exclude Done ☐ Pending

Billing Date:

Batch Number:

Apply Cancel Help Defaults

In the **List Only Claims that Match** window, use one or more of the options to limit the claims you want to appear in the window.

F1 Look up List Only Claims that Match

Changing Claim Status

In the **Claim Management** window, all submitted claims are automatically marked Sent with an indication of the method of submission. There may be occasions when you need to change this status.

Entire Batch

If the status of an entire batch needs to be changed, you can change all the claims at once. Highlight one of the claims and note the number listed in the **Batch 1** column in the **Claim Management** window. Click **Change Status**. The **Change Claim Status/Billing Method** window is opened.

Change Claim Status/Billing Method

Change Status/Billing Method of Claims For

☒ Batch : ☐ Selected Claim(s)

Status From

☐ Hold
☐ Ready to send
☐ Sent
☐ Rejected
☐ Challenge
☐ Alert
☐ Done
☐ Pending
☐ Any status type

Status To

☐ Hold
☐ Ready to send
☐ Sent
☐ Rejected
☐ Challenge
☐ Alert
☐ Done
☐ Pending

Billing Method From

☐ Paper
☐ Electronic

Billing Method To

☐ Paper
☐ Electronic

For Carrier

☐ Primary
☐ Secondary
☐ Tertiary
☒ All

OK
Cancel
Help

Choose the **Batch** radio button and enter the batch number from the **Batch 1** column in the **Claim Management** window. Then choose the appropriate radio buttons in the **Status From** and **Status To** sections. All claims with that batch number have the status changed when you click **OK**.

Selecting Multiple Claims

When only one or a few claims within the same batch or claims from multiple batches need a status change, hold down the **CTRL** key and click each claim that needs the status changed. Note that the selected claims do not need to have the same claim status to begin with, but they are all changed to the same status. Click **Edit**.

In the **Change Claim Status/Billing Method** window, choose the **Selected Claim(s)** radio button, then choose the appropriate radio buttons in the **Status From** and **Status To** sections. If you have chosen claims with varying statuses, choose **Any status type** in the **Status From** section. When finished, click **OK**.

F1 Look up Change Claim Status/Billing Method and Marking Claims

Sending Claims to a File

Medisoft has the ability to print CMS or UB-04 claim data to a text file. You process the claims like you are sending electronic claims through one of the electronic claims modules only you create the file on your desktop instead of sending it to the clearinghouse or insurance company.

F1 Look up Sending Claims to a File.

Creating Statements

Statement Management

NOTE: This is an Advanced and above feature.

This section explains briefly how to manage statements within the **Statement Management** window and includes creating, editing, printing/reprinting, and listing statements, as well as changing statement status.

To perform any statement management functions, go to the **Activities** menu and select **Statement Management**.

You can also track patients that do not immediately pay their copay using the Copay Remainder statement. This format is only available when processing statements using the Statement Manager feature. Before using this statement format, you will need to select the Add Copays to Remainder Statements box on the Program Options window, Billing tab.

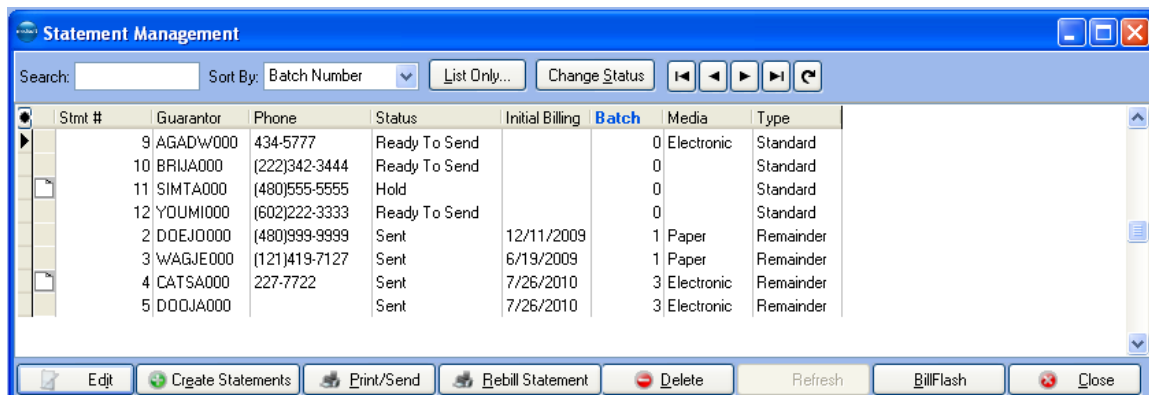
F1 Look up Program Options window, Billing tab

F1 Look up Tracking Missed Copays

You can use Statement Management to create, to bill, and to rebill statements all from one place. You can also view information about the statement, such as the guarantor, the status, the initial billing date, and the type. You can also generate statements to track missed copays. For more information, on setting up and using this feature, see the topic Tracking Missed Copays.

Statement Management Window

The **Statement Management** window has several sections:



Header

Search: Enter values for which you want to search in the grid. This field is affected by the variable in the Sort By field.

Sort By: Click the down arrow to select the variable by which you want to search. If you want to sort by Submission Count, you have to add that column to the grid to see the counts. For more information, see:

F1 Look up Grid Columns

List Only: Click this button to list only certain statements in the grid. For more information, see:

F1 List Only Statements that Match

Change Status: Click this button to change the status on a batch of statements. For more information, see:

F1 Change Statement Status/Billing Method

Navigation Buttons: These buttons in the upper right corner of the window allow you to move through the displayed records. The button at the right end of the navigation buttons refreshes the information in the grid.

Buttons

Edit: Click this button to edit the selected statement. For more information, see:

F1 Look up See Edit Statement

Create Statements: Click this button to create statements. For more information, see:

F1 Create Statements

Print/Send: Click this button to print the statements on paper or send them electronically. For more information, see:

F1 Print/Send Statements

Rebill Statement: Click this button to rebill statements. For more information, see

F1 See Rebilling Statements

Delete: Click this button to delete the statement number and release the transactions bound to the statement. You can then put those transactions on a different statement.

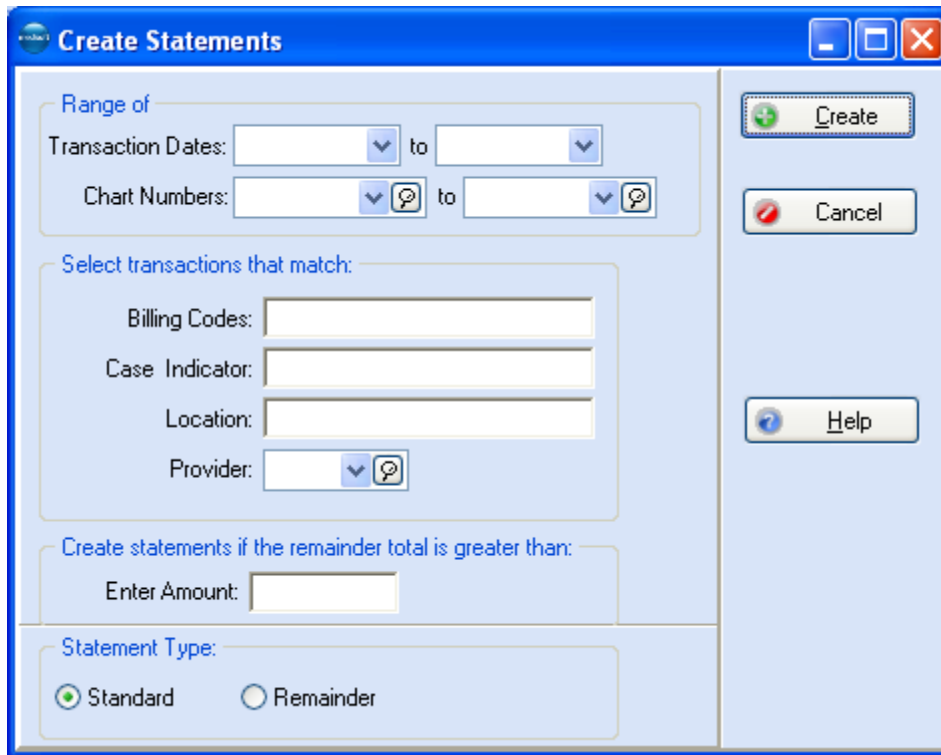
NOTE: If you delete electronic statements that have already been billed and decide to recreate them, the program will automatically assign a media of Paper to those statements.

F1 Recreating Electronic Statements

Close: Click this button to close the window.

Creating Statements

Click **Create Statements** to gather available transactions onto a statement.



Create Statements

Range of

Transaction Dates: [] to []

Chart Numbers: [] to []

Select transactions that match:

Billing Codes: []

Case Indicator: []

Location: []

Provider: []

Create statements if the remainder total is greater than:

Enter Amount: []

Statement Type:

☒ Standard ☐ Remainder

Create

Cancel

Help

You can create a single statement or an entire batch. Enter ranges of transaction dates and/or chart numbers to control which statements are created. Also, you can further limit the statements created by entering information in the **Select transactions that match**, **Include statements if the remainder total is greater than**, and **Statement Type** areas of the window.

F1 Look up Create Statements

Editing Statements

Highlight a specific statement and click **Edit** or press **F9** to edit a statement. You can modify general statement information, the transactions that appear on the statement, and any comments attached to the statement. When you make changes in the **Statement** edit window, you modify only that statement and do not affect the defaults for other statements.

Statement: 11

Statement: 11 Statement Created: 12/22/2003

Guarantor: SIMTA000 **Tanus J Simpson**

Remainder: \$386.00

General | Transactions | Comment

Status

☒ Hold

☐ Ready to Send

☐ Sent

☐ Failed

☐ Challenge

☐ Done

Billing Method

☐ Paper

☐ Electronic

Type: S - Standard

Initial Billing Date:

Batch: 0

Submission Count: 0

Billing Date: ▼

Save

Cancel

Help

The detail also indicates submission method assigned to the statement (paper or electronic), as well as the statement status. Statement status options include: **Hold**, **Ready to send**, **Sent**, **Failed**, **Challenge** or **Done**. You can also see the statement type, initial billing date, batch number, submission count, and most current billing date.

Any time a statement is sent, the program assigns the statement a batch number. That number shows in the **Batch** field. The program also updates the submission count, the number of times the statement has been sent, and the billing date.

The Transactions tab shows all the transactions that appear on the statement. You can split, add to, or remove transactions from statements in this tab. The Comment tab provides an empty box in which to place whatever comments you feel are necessary concerning this statement and/or any transactions relating to it. If you add a note here, an icon is displayed next to the statement in **Statement Management**. You can double-click the note to view or edit the note.

F1 Look up Edit Statement

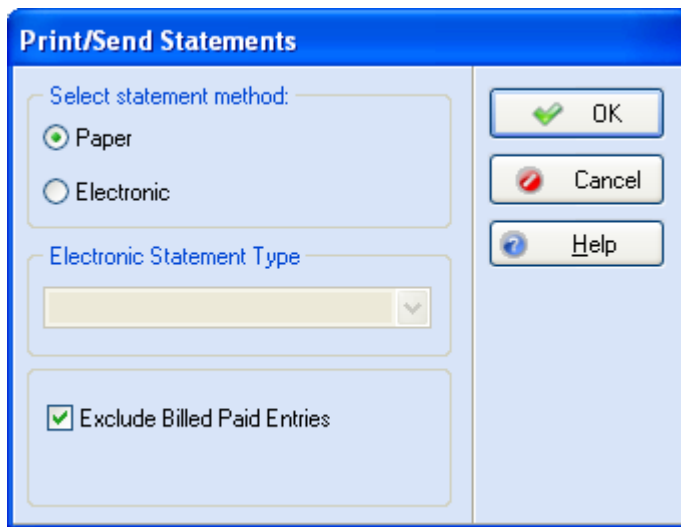
Converting Statements

To make it easier to use Statement Management, you can now easily convert old statements into Statement Management statements in the format's report properties. This is done through the **Design Custom Reports and Bills** option in the **Reports Menu**.

F1 Look up Converting a Statement Format to a Statement Management Format

Printing Statements

Once statements are created, click **Print/Send** to process them. Indicate whether you are sending the statements on paper or electronically. If you are sending statements electronically, specify the format for the statements. Then apply filters on the Data Selection Questions window to select only those statements you want to send.



TIP: Use the True option on the In Collection Match check box to display only records that meet the criteria of true or in collections. Selecting False will not apply the filter. A field left blank has no limits placed on it and the program searches the entire database and includes all information that fits the criteria.

Use the Txn Sort Order list to sort transactions within a statement and to the statements as a group. Choices include: Entry order, Date of Service, and Document Number.

F1 Look up Print/Send Statements

F1 Look up Data Selection Questions

Reprinting Statements

If necessary, you can reprint statements without regard to their status. To reprint an entire batch, the status must be changed for the batch.

F1 Look up Reprinting Statements

Listing Statements

Click **List Only** to view only those statements that match a set of criteria that you define.

In the **List Only Statements that Match** window, use one or more of the options to limit the statements you want to appear in the window.

List Only Statements That Match

Chart Number:

Statement Created:

Billing Date:

Batch Number:

Billing Method

☒ All
☐ Paper
☐ Electronic

Status

☒ All
☐ Hold
☐ Ready to Send
☐ Sent
☐ Failed
☐ Done ☒ Exclude Done
☐ Challenge

Submission Count: 0

☒ Apply
☐ Cancel
☐ Help

F1 Look up List Only Statements that Match

Changing Statement Status

In the **Statement Management** window, all submitted statements are automatically marked **Sent** with an indication of the method of submission. There may be occasions when you need to change this status.

Statements sent electronically through BillFlash get a report that marks each statement as either accepted or rejected.

Entire Batch

If the status of an entire batch needs to be changed, you can change all the statements at once. Highlight one of the statements and note the number listed in the **Batch** column in the **Statement Management** window. Click **Change Status**. The **Change Statement Status/Billing Method** window is opened.

Choose the **Batch** radio button and enter the batch number from the **Batch** column in the **Statement Management** window. Then choose the appropriate radio buttons in the **Status From** and **Status To** sections. All statements with that batch number have the status changed when you click **OK**.

Selecting Multiple Statements

When only one or a few statements within the same batch or statements from multiple batches need a status change, hold down the **CTRL** key and click each statement that needs the status changed. Note that the selected statements do not need to have the same status to begin with, but they are all changed to the same status. Click **Edit**.

In the **Change Statement Status/Billing Method** window, choose the **Selected Statement(s)** radio button, then choose the appropriate radio buttons in the **Status From** and **Status To** sections. If you have chosen statements with varying statuses, choose **Any Status Type** in the **Status From** section. When finished, click **OK**.

F1 Look up Change Statement Status/Billing Method and Marking Statements

Billing Cycles

The cycle billing feature lets you print statements every certain number of days. If you want to print statements every 30 days, you can set up a billing cycle of that length. First you set up the billing cycle in **Program Options**, Billing tab. Then you process the statements through **Statement Management**. The other ways of printing statements do not offer this feature.

F1 Look up Cycle Billing

Claim Rejection Messages

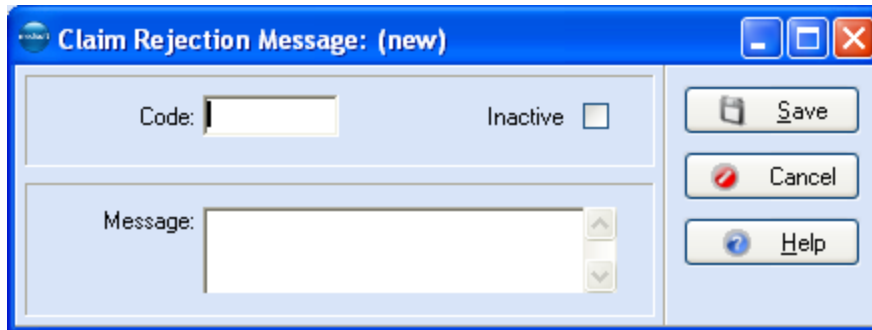
Use this window to enter claim rejection messages received on an EOB (Explanation of Benefits). These messages can then be attached to transactions and printed on statements to explain why the claim was rejected. You connect the message to a transaction in the **Rejection** field when applying deposits from the insurance company.

If the EOB shows a code for a certain procedure, you can enter or select the code in the Rejection field found in the **Apply Payment/Adjustments to Charges** window. You can then

format a statement that prints transaction statement notes. Using this reformatted statement, the program prints the claim rejection messages on patient statements.

F1 Look up Format/Design Reports

Go to the **Lists** menu and select **Claim Rejection Messages**. The **Claim Rejection Message** list window opens. Click **New** to create a new rejection message or select an entry on the grid, and click **Edit**.



TIP: When applying a claim rejection message to a line item in the Apply Payment/Adjustments to Charges window, use the F8 and F9 keyboard shortcuts. Click the Rejection column and click F8 to create a new rejection message or click F9 to edit an existing rejection message. In the **Code** field, enter the claim rejection message code. In the **Message** field, enter the message.

F1 Look up Claim Rejection Message Entry

F1 Look up Apply Payment/Adjustments to Charges Grid

Troubleshooting Statement Printing

Patient Remainder Statements

NOTE: This is an Advanced and above feature.

If you are having trouble printing patient remainder statements, check to be sure the following items have been performed:

- The patient has insurance coverage other than Medicare. This is indicated in the patient **Case** window, Policy 1 tab, **Insurance 1** field (also Policy 2 and Policy 3 tabs if there is secondary and/or tertiary coverage).
- A charge has been posted in the patient case.
- A claim has been created.
- An insurance payment or adjustment has been posted, applied, and marked as Complete to the account for each applicable carrier.

Applying Deposits

Deposit/Payment Application

NOTE: This is an Advanced and above feature.

This feature makes creating a deposit list and applying payments, especially EOB payments from insurance carriers, an easy process. In many ways, it is a more convenient place to apply payments than **Transaction Entry** because you enter one deposit, then distribute the payment to as many cases as necessary, then click one button and all the transactions are created at one time. If necessary, within the same window, open a different patient record and continue distributing payments.

F1 Look up Deposit Entry

F1 Look up Apply Payment/Adjustments to Charges, and Program Options

Go to the **Activities** menu and select **Enter Deposits/Payments** to open the **Deposit List** window.

In this window, you can select a payment to apply, edit a payment, or create a new payment. The deposit date does not have to be the current date (but the transactions entered still appear on the current day's activity reports).

TIP: To save time and increase work efficiency, you can close a case after applying payment by right-clicking the line item in the grid and then selecting Close Case. At a later date in File Maintenance, closed cases can be deleted from the database.

Select an entry on the grid and click the Detail button to pull up an information-only window that displays all the activity the selected deposit. You cannot make changes in this window.

If needed, you can print item details.

Deposit Detail

Deposit Date: 12/22/2003 Deposit Amount: \$200.00 ☐ Hide Charges

Charge Reference	Entry Number	Chart Number	Patient Name	Prod/Chrg Code	Prod/Chrg Amount
	0	83 BRIJA000	Brimley, Jay		

Buttons: Close, Print Grid

F1 Look up Print an Entry from the Deposit List

When you highlight a payment and click **Apply**, the **Apply Payment/Adjustments to Charges** window is opened.

Apply Payment/Adjustments to Charges

Aetna Ins 1: Medicare (MED01) List Only... Unapplied Amount: \$15.00
 For: AGADW000 Again, Dwight Ins 2: Aetna (AET00) View So Far... ☒ Show Unpaid Only
 Ins 3:

Payment Procedure Codes: AP DEDUC APWH APWRD TAKEBA

	Date	Procedure	Charge	Remainder	Payment	Deductible	Withhold	Allowed	Adjustment	Take Back	Complete	Rejection	Provider
	11/21/2002	99213	60.00	12.00				0.00			☐		REL
	11/21/2002	72052	80.00	17.00				0.00			☐		REL
	11/21/2002	97010	10.00	2.00				0.00			☐		REL
	03/09/2007	99213	60.00	60.00				0.00			☐		REL

Summary: \$0.00 \$91.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00 \$0.00

Options... There are 4 charge entries.

- ☒ Alert When Claims Are Done
- ☒ Alert When Statements Are Done
- ☒ Bill Remaining Insurances Now
- ☒ Print Statement Now
- ☐ Write off Balance Now

Buttons: Save Payments/Adjustments, Close, View Transactions

In this window, select the patient chart number (if you have chosen an insurance payment) and apply the portion of the payment to the applicable charge(s). When finished, click **Save Payments/Adjustments** to create the transactions.

TIP: If you check **Print Statement Now** and click **Save Payments/Adjustments**, you print statements from **Statement Management**.

Then, if you need to apply payments from the same deposit to another patient record, select the next patient chart number and continue making payment applications. This window is also tied to the Payment Application tab of **Program Options**. Unless deactivated, all payment applications are automatically checked as paid in full by the payer, allowed amounts are calculated on all charges, and any charges over the calculated allowed amounts are automatically entered in the **Adjustment** field.

TIP: Be sure to click **Save Payments/Adjustments** before closing this window or transactions cannot be created.

The payment application feature is designed specifically to closely match the format of an EOB. When you receive an EOB with a payment from an insurance carrier, open the **Deposit List** window, create the total amount deposit, and then apply the payment to the cases as specified in the EOB.

EOB Payments

Part of the payment structure to a healthcare office from an insurance carrier involves a check and an "Explanation of Benefits." Widely known throughout the industry as the EOB, it lists claims for which payment is being made and, in some cases, an explanation of what is not being paid and why.

Not every insurance claim that is filed with a carrier is paid in full. It may be that payment is 80 percent of the claim or it may be 50 percent. Other times a claim may be totally or partially disallowed. The EOB explains in these cases. Normally the part that is not paid by the carrier is picked up by a secondary carrier or charged back to the patient.

When an EOB is received, a transaction must be entered to offset the charges. This is done by creating a deposit in the **Deposit List** window. If the EOB check covers several charges, distributing a payment to specific charges can be handled by clicking **Apply**. The window lets you select the patient records and claims to be paid and designate how much goes to each.

F1 Look up EOB Payments/Managed Care/Capitation Payments

Managed Care

One of the important sources of patients and income in many practices has begun to be managed care organizations. In each instance, the HMO or PPO provides a list of patients who have selected your practice as their primary care provider. Payment is made to your practice on a per-patient basis, regardless of whether the patient ever visits the office. When a patient does come in for treatment, he or she pays a set co-pay amount.

The co-pay is charged only by the primary care facility or the facility to which the patient is referred by the primary care facility. After a patient's visit to the doctor's office, a claim is filed and sent to the carrier. When the EOB is returned, there is seldom a payment included, since payment is made under the capitation program for managed care organizations.

F1 Look up EOB Payments/Managed Care/Capitation Payments

Capitation Payment

The basis for capitation payments is to provide healthcare for a fixed cost, irrespective of the amount of service required by each individual patient. This is done in connection with the managed healthcare services such as HMOs and PPOs. There is no direct relationship between the capitation payment received by the practice and the number of patients covered by the plan who actually visit the practice for treatment. Capitation payments are not posted to patient accounts but are entered in the **Deposit List** window. If it is necessary to zero out a patient account, create a zero deposit for the carrier. For each patient covered by the capitation payment who has an outstanding balance, zero out the account by entering the remainder in the **Adjustment** field. When it is applied, the payment shows as zero and the patient's balance shows as a write off in the **Adjustment** field in the **Transaction Entry** window.

F1 Look up EOB Payments/Managed Care/Capitation Payments

Managing Collections and Small Balance Write-Offs

Collection List

The collection list is a central place where you can manage accounts that are in collections. Ticklers or collection reminders are displayed as collection list items. Go to the **Activities** menu and select **Collection List**.

NOTE: Security must be activated before this feature can be used.

Item	Responsible Party	Type	Patient	Action	Statement Number	Remainder Balance	Insurance Estimate	Claim Number	Claim Total	Status	Follow Up Date
------	-------------------	------	---------	--------	------------------	-------------------	--------------------	--------------	-------------	--------	----------------

What appears in the collection list depends on the user login. The program displays the collection list item for the current user, unless the user has administrative access. Administrators can choose to view all or selected users' collection list items.

To enter items in the collection list, click **New** while in the collection list. Fill in the necessary information.

F1 Look up Collection List

TIP: Use the F7 keyboard shortcut on the Collection List to launch the Quick Ledger. Select a line item on the Collection List grid and press F7 to display the patient's record in the Quick Ledger.

Add Collection List Items

The option to add collection items through reports is no longer an option. However, you can add collection items with the new **Add Items** option in the Collection List. This feature lets you create tickler items based on criteria you enter in the **Add Collection List Items** window.

Add Collection List Items

Add items based on ...

☐ Statements ☒ Claims

Carriers

☒ All ☐ Primary ☐ Secondary ☐ Tertiary

Claim:

Status

☒ All ☐ Rejected ☐ Challenge

Range of:

Insurances: [] to []

Initial Billing Date: [] to []

Billing Date: [] to []

Add item if submission count is greater than:

Enter Number: []

Add item if patient remainder balance is greater than:

Enter Amount: []

Add Delinquent Payments:

☐ Missed Payments for Patient Payment Plan: []

Assign To: []

☐ Add Billing Comment to Office Notes

Buttons: Add Items, Cancel, Help, Defaults

F1 Look up Add Collection List Items

Patient Payment Plans

To help patients make consistent payments on their accounts, create payment plans. You can create as many plans as necessary to accommodate your patients. Go to the **Lists** menu and select **Patient Payment Plan**.

Patient Payment Plan List

Search for: Field: Code

Code	Description	1st Payment Due on	Interval in Days	Amount Due	Date Modified
AA	Code AA	5	30	\$10.00	10/18/2004 1
AB	Code AB	10	25	\$20.00	10/18/2004 1
AC	Code AC	15	20	\$30.00	10/18/2004 1

Buttons: Edit, New, Delete, Print Grid, Close

Once you create a plan, open the **Patient/Guarantor** window, Payment Plan tab, and assign the plan to the patient's record. The particulars for the plan appear in fields in this tab.

Patient Payment Plan: Code AA

Code: AA Inactive ☐

Description: Code AA

First Payment Due: 5 day of the month

Due Every: 30 days

Amount Due: \$10.00

Buttons: Save, Cancel, Help

The program records and tracks the scheduled date for the next payment and the amount to be applied. If the patient follows the payment plan (e.g., the patient pays the required amount by the required date), this account is not included when you process collection letters. If the patient does not follow the payment plan, the account is included when you process collection letters.

F1 Look up Patient Payment Plan Entry

Collection Letters

Once you put a patient-responsible account in collections, you can create collection letters to follow up with the patient.

To print collection letters, go to the **Reports** menu, select **Collection Reports**, and then select **Patient Collection Letters**. You must print the Collection Letter Report before you print collection letters.

In the **Data Selection Question** window, click the **Exclude items that follow Payment Plan** check box to activate **Generate Collection Letters** box. Check the **Generate Collection Letters** box.

F1 Look up Collection Letters and Collection Letter Report

Customizing Collection Letters

Customize the collection letter format through the Collection Letter Wizard. Go to the **Tools** menu and select **Collection Letter Wizard**.

The things you can customize are the name and address, contact phone number, and sender's name. Make your selections and click either **OK** or **Preview**.

Access the new format through the **Custom Report List**. New formats are named WzCollections **date** (using the date on which the format was revised). If you create several new formats in a single day, you can distinguish them by the order in which you created them. Click **Show File Names** to reveal the format file names. This shows the file names (which are mrcol[#], numbered sequentially), type and date and time last modified.

F1 Open the Collection Letter Wizard and then look up Collection Letter Selection

Small Balance Write-off

This feature lets you automatically write off remainder balances of a certain amount. The balance written off is the patient remainder balance. You can write off small remainder balances as a batch in the **Small Balance Write-off** window or for one patient at a time in the **Apply Charges/Adjustments to Payments** window.

F1 Look up Small Balance Write-off Overview

Writing off a Balance

To access the **Small Balance Write-off** window, select **Small Balance Write-off** from the **Activities** menu.

The window is divided into two sections. In the first section, select criteria for the type of remainder balances you want to write-off and click apply. In the second section, a list of the patients who meet the criteria appears in the **Write-off Preview List**. The default is set to write off all records in the list. You can select individual records to write off by clicking on the record. Multiple records can be selected by pressing the **CTRL** key and clicking the record. Click **Write off** to write off the selected remainder balances.

Use the Stmt Submission Count + field to define a maximum amount of times that you want to send a statement before writing off the balance. Once this number is met, the small balance is written off. The program selects patients whose statements have been sent (submission count) more than the value entered in the field. Once this number is met, the small balance is written off. This field works in conjunction with the other fields on this window, and if a value is entered in this field, the balance is only written off if it meets the criteria for this field (completed the statements) and the other fields such as Maximum Amount field. For instance, if you enter 3 in this field and 10 in the Maximum Amount field, small balances would be written off after 3 statements are sent and if the balance is under \$10.00.

When the program writes off the remainder balances it updates a number of other features. Write-off entries are created and applied to all patient responsible charges associated with the selected patient. The program also updates the associated **Collection List** items, refreshing balances and marking zero balances as deleted. After a remainder balance write off, statements are changed to the status of **Done** and a note is added to the write-off entries.

F1 Look up Small Balance Write-off

Using Electronic Services

Electronic Claims Processing

Electronic claims send your insurance claims online either directly to the insurance carrier or to a clearinghouse that then sends the claims to the insurance carrier. Medisoft currently offers modules that send to a clearinghouse and modules that send directly to insurance carriers via the Revenue Management feature. This solution is offered in two forms: Revenue Management Advanced and Revenue Management Direct.

Revenue Management Advanced uses the RelayHealth clearinghouse for electronic claims processing and eligibility verification. With Medisoft 17, there is no cost for this software option though there are clearinghouse charges. For more information on pricing, contact your local value added reseller or Medisoft sales at 800-333-4747.

Revenue Management Direct provides pre-configured connectivity to the most popular direct payers and also supports adding connections to other payers or clearinghouses. This solution is available as an annual subscription with additional fees per direct connection. For more information on pricing, contact your local value added reseller or Medisoft sales at 800-333-4747.

With either option, Revenue Management provides a flexible tool that lets you manage your claims processing environment and, if necessary, make changes without completely replacing your EDI software.

Revenue Management differs from other EDI solutions by virtue of its design; it is an integrated component of Medisoft which means that the company that produces your practice management solution also produces your EDI solution—a complete revenue management solution that seamlessly updates claim status and date sent while also providing ERA (electronic remittance advice) posting and eligibility verification.

F1 Look up Electronic Claims Overview

Statement Processing

You can send statements electronically through BillFlash, the web-based company that is set up to process Medisoft electronic statements. Statements sent electronically through Billflash get an instant response report that tells what information was sent.

F1 Look up BillFlash

Receive/Send Reports through Medisoft Terminal

Within Medisoft, the Medisoft Terminal option can be used to send or receive reports by connecting to various bulletin boards using a modem. The BBS (Bulletin Board Service) is set up through Medisoft Terminal.

F1 Look up Medisoft Terminal

Eligibility Verification

The Eligibility Verification feature lets you check a patient's insurance coverage online. The Revenue Management feature conducts eligibility verification.

Contact the Medisoft sales department at (800) 333-4747 for information on pricing. You must have broadband internet service to make eligibility verification inquiries.

Eligibility Verification Setup

To set up Medisoft for eligibility requests, you must make sure the Tax ID is entered on the Practice Information window, Practice IDs grid. You must also enter information in the Providers, Insurance Carriers, and Patients windows.

You must also apply security to your practice and create at least one user. For more information on Medisoft security and setting up users, see *Setting up Security*.

F1 Look up Eligibility Verification Overview

Practice Information: Click **File** and select **Practice Information**. Click the **Practice IDs** tab. On the **Practice IDs** grid, make sure there is an entry on the grid with the Practice Tax ID populated.

Providers: Click **Lists** and select **Provider** and **Providers**. On the **Provider List** window open the provider whose patients you want to verify. Make sure the following fields are populated:

Provider IDs Tab: On the Provider IDs grid, make sure there is an entry on the grid with the Tax ID populated.

Insurance Carriers: Click **Lists** and select **Insurance** and select **Insurance Carriers**. On the **Insurance Carrier List** window, select the insurance record for which you want to verify coverage. Make sure the following field is populated:

EDI/Eligibility tab: Click the magnifying glass in the **Claims Payer ID** field to search for the payer associated with this insurance company. The Payer ID Lookup window opens. If you select the payer and the Eligibility Payer ID field is blank, then the clearinghouse to which Medisoft sends verification requests does not support that payer at this time for eligibility requests.

NOTE: Some carriers require Group NPI numbers instead of Individual NPI numbers for individual practitioners. If one of your carriers requires a Group NPI number, you will need to set up a separate entry on the Provider IDs grid for handling this type of dual NPI environment. For more information:

F1 Setting up Mixed NPI Numbers for Eligibility.

Patients: Fields in the **Patient / Guarantor** window must be populated for each patient. On the Name, Address tab, enter information in the following fields: **Last Name**, **First Name**, **Date of Birth**, **Gender**, and **Social Security Number**. On the **Other Information** tab, enter information in the **Assigned Provider** field.

Cases: Fields in the **Case** window must be populated for each patient. On the **Policy 1**, **Policy 2**, and **Policy 3** tabs, enter information in the following fields: **Insurance**, **Policy Holder**, **Relationship to Insured**, and **Policy Number**. On the **Account** tab, enter information in the **Assigned Provider** field.

F1 Look up Patient/Guarantor Entry and Look up Case Entry

Eligibility Verification Results

There are multiple places in the program from which you can make eligibility verification requests: the Eligibility Verification Results window, the Patient List window, Office Hours, and the Task Scheduler window. The type of eligibility inquiry you make, either real-time or scheduled, depends on the window from which you are making the request.

Eligibility Verification Results

If you access this window from the Activities menu, the list will automatically show the last inquiry made for each patient. You can also set it to show all inquiries. To make a real-time eligibility inquiry from the Eligibility Verification Results screen, highlight the patient and click Verify.

Patients

To make a real-time eligibility inquiry for a specific patient, right-click the patient's case in the Patient List and select Eligibility Verification. The Eligibility Verification Results screen opens for the patient. Click the Verify button to make the inquiry. You can also open the patient's case and click Eligibility.

Office Hours

To make a real-time eligibility inquiry for a specific patient from the appointment grid, right-click the patient's appointment and select Verify Eligibility. The Eligibility Verification Results screen opens for the patient. Click the Verify button to make the inquiry.

Task Scheduler

You can use the Scheduled Tasks feature to schedule a daily time to send a batch of eligibility inquiries. To schedule the batch, go to the Activities menu, select Eligibility Verification, and then select Schedule. The task will automatically make inquiries for patients scheduled in the appointment grid up to a week in advance.

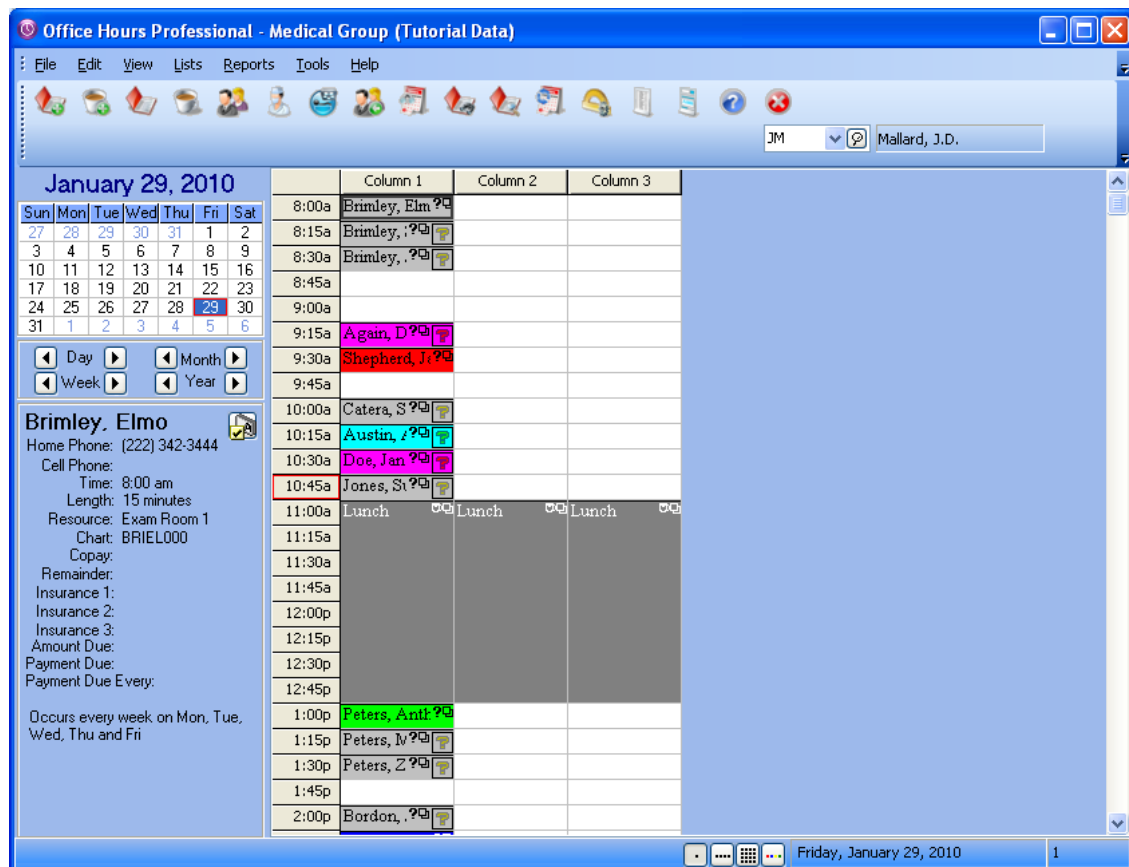
TIP: Press F10 to launch the **Eligibility Verification Results** window to verify a patient's eligibility.

Scheduling Appointments

Office Hours Overview

Office Hours is an appointment scheduling program that helps keep track of appointments for your practice. It is automatically installed with Medisoft.

If you purchased Office Hours Professional, the features of this program are specifically marked as Office Hours Professional features in the documentation.



Starting Office Hours

If you are working in Medisoft, click the Appointment Book speed button or go to the **Activities** menu and select **Appointment Book**.

Accessing Office Hours from Other Programs

You can access Office Hours at the same time as you are working in other Windows-based programs. Open Office Hours at the beginning of each day and then minimize it. Press **ALT + TAB** at the same time to activate Office Hours, perform the desired scheduling tasks, and then minimize it to return to your previous task.

Office Hours Setup

Office Hours Setup

There are several portions of the program that need to be set up before you can start scheduling.

First, set up provider records in Medisoft unless you are using Office Hours Stand Alone.

NOTE: If you create a provider in Office Hours, you will need to finish setting up the provider in Medisoft. The Provider IDs tab and grid is not available in any version of Office Hours.

If you are booking appointments for lab work or therapy, each of those technicians should have a provider number and schedule and so should each office member whose schedule is included in the Office Hours program.

Second, create your resource records. You can include all treatment apparatuses in this list, as well as consultation and treatment rooms, so that you do not double book a room or equipment.

Third, establish the number of booking columns you want.

Fourth, clarify program options, such as establishing appointment length, creating whatever views you need for viewing multiple columns at once, and deciding how much information you want displayed in your appointment blocks in the appointment grid.

Fifth, set up breaks and recurring breaks, to show lunch hour, set breaks, seminars, etc.

Setting up Provider Records

Office Hours must have at least one provider record set up in order to run. If no provider record is set up, Office Hours automatically prompts you to do so--the Providers window is available from the **Lists** menu in Office Hours.

NOTE: If you create a provider in Office Hours, you will need to finish setting up the provider in Medisoft. The Provider IDs tab and grid is not available in any version of Office Hours.

If you want, you can let the program assign the **Code** for the provider or you can enter a five-character code yourself.

Enter the provider's name and pertinent information. Enter NPI information, taxonomy, and other rules in Medisoft in the Providers window on the Provider IDs tab.

F1 Look up Provider Entry

Setting up Patient Records

This can be done in either Medisoft or Office Hours. Click **Lists** and select **Patient List**. You can create a chart number yourself (eight alphanumeric characters) or let the program create one. Enter information in as many of the fields as necessary in both tabs. When finished, click **Save**. Repeat this process for each patient who visits your practice.

F1 Look up Patient Entry

Setting up Case Records

This can be done in either Medisoft or Office Hours. Click **Lists** and select **Patient List**. Click the **Case** button in the top-right corner of the window and click **New Case** or press **F8** to display the **Case: Patient Name (new)** window. Enter information in as many of the fields as necessary. When finished, click **Save**. Repeat this process for each case you want to enter.

TIP: In the **Case** window, you cannot press **F8** or **F9** to access records available from lookup fields, such as **Facility** or **Attorney**. The **F8** and **F9** keys are only available in the **Case** window from within Medisoft itself.

F1 Look up Case Entry

Setting up Resource Records

The **Resource List** is a tool to help you manage the scheduling of rooms and equipment in the office. To create the list, click **Lists** and select **Resource List**. In the **Resource List** window, click **New** or press **F8**.

Create a code for the resource or let the program create one based on the description. Enter a description (e.g., Room 1, Treadmill, etc.) and click **Save**. Repeat this process until all rooms and/or equipment are contained in the list.

F1 Look up Resource Entry

Setting an Appointment

Setting an Appointment

To set an appointment in Office Hours, first select the provider from the provider box at the top right of the toolbar. In any Multi View (Office Hours Professional), select the provider by clicking in the appropriate provider's column.

Select a date for the appointment. You can use the **Day**, **Week**, **Month**, and **Year** selection arrows below the calendar to locate the correct date, or use the Go to Date feature (available from the **Edit** menu).

Next, in the appointment grid, double-click a time slot, which is highlighted with a heavy line border. You can also right-click the time slot and select **New Appointments** or press **F8**; or, go to the **Lists** menu and select **Appointment List** and then click **New** to open the **New Appointment Entry** window.

New Appointment Entry 

Chart:  

Home Phone: Cell Phone:

Resource:  

Note:  

Case:  

Reason:  

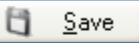
Length: 15   minutes

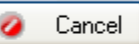
Date: 1/29/2010  Time: 8:45 am

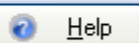
Provider: JM   Mallard, J.D.

Repeat: No Repeat



 Save

 Cancel

 Help

Enter or select the chart number of the person for whom the appointment is being set. If the person's information has been entered in the program, the name and phone number are automatically entered and the patient's last case is reflected in the **Case** field.

TIP: After you select a chart number and move to another field (click or TAB key), if the patient has a future appointment scheduled, the Patient Has Future Appointment warning field appears. Click the magnifying glass or press ALT + A to review the scheduled future appointments before finalizing the new appointment. This feature is available for Office Hours Professional.

Assign a resource. If the resource or room you need is not in the list, press **F8** to create a new resource record. The **Notes** field lets you include a reminder message regarding the patient's need or condition. Enter an appointment reason in the **Reason** field. If necessary, change the **Length**, **Date**, and **Time** fields here. You can also change the appointment color. If there is a need for repeat visits, click **Change** in the **Repeat** section. See the following **Repeating Appointments** section.

F1 Look up New Appointment Entry

Repeating Appointments

When a patient needs to make regular return visits, set up repeat appointments through the **New Appointment Entry** or **Edit Appointment** window. Click **Change** in the **Repeat** section at the bottom of the window. The **Repeat Change** window that opens is the same window that appears when creating repeating breaks.

In the **Frequency** box, select the interval for the repeating appointment. Choosing any of the radio buttons (except **None**) displays different data entry boxes in the middle of the window that

give you the repeat options for each frequency. Also, a written summary of the selected frequency appears in the bottom middle area of the box.

It is important to note that when you set up an appointment using the **Monthly** frequency, the date highlighted on the main calendar affects the day or date that is entered in the break note.

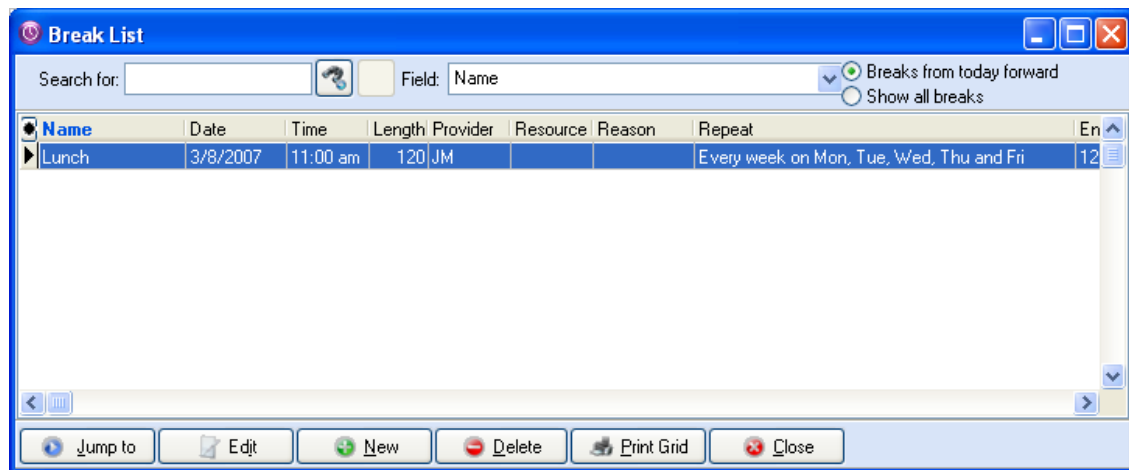
F1 Look up Repeat Change

Entering Breaks

Entering Breaks

You can enter breaks into the appointment schedule as reminders that the time slots are committed. Some breaks are a one-time occurrence, like a vacation or a seminar. Others are regularly scheduled times for each month or week.

Click **Lists** and select **Break List**. Click **New** or press **F8** in the **Break List** window.



To create a break, give it a name, a date, and enter the time that the break starts. Using the up and down arrows, enter the length of time in minutes. The display color of the break should be contrasting to the regular daily appointment schedule (the default is gray).

If the All Columns box is checked, all columns in the schedule display will be marked with this break. If this box is not checked, only one column will contain the break.

The Provider(s) field contains three buttons: Current, Some, and All. If you select Some, the Provider Selection window opens when you save the break so you can select the appropriate providers.

NOTE: If you click New in the Break List to create a break, this field does not include Current. That is because breaks for all providers are included in the Break List. If only one provider is affected by the break, click Some and then select only the one provider.

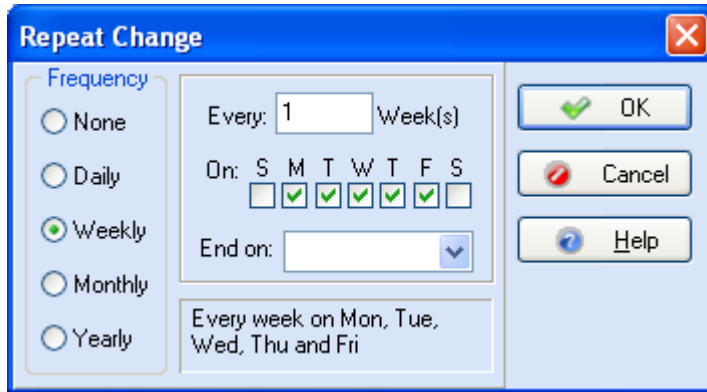
Select either the **Some** button or **All** button to apply the break to providers you select or all providers. If you select the **Some** button when you click **Save**, the **Provider Selection** window appears. Click one or more providers and then click **OK**.

The Print Grid feature is available with Office Hours Professional.

F1 Look up New Break Entry

Setting Up Repeating Breaks

In the **New Break Entry** window is a box marked **Repeat**. The **Change** button is next to this box. Clicking **Change** opens the **Repeat Change** window where you can establish the **Frequency** of the break.



Choosing any of the radio buttons (except **None**) displays different data entry boxes in the middle of the window that give you the repeat options for each frequency. Also, a written summary of the selected frequency appears in the bottom middle area of the box.

It is important to note that when you set up a break using the **Monthly** frequency, the date highlighted on the main calendar affects the day or date that is entered in the break note.

Moving/Deleting Appointments

Changing Appointment Status

NOTE: This is a feature of Office Hours Professional feature.

There are multiple options for marking the status of an appointment.

The default is **Unconfirmed**. When any change in status occurs, edit the appointment or right-click on the appointment and choose the appropriate radio button. If you choose **Cancelled**, the appointment is removed from the grid display. Any other status is reflected by a small icon in the upper right corner of the appointment in the grid.

Moving an Appointment

If you want to move the appointment to another day or time, click the appointment and press **CTRL + X** (or go to the **Edit** menu and select **Cut**). Move the cursor to the new day and/or time slot, and either press **CTRL + V** or select **Paste** in the **Edit** menu. If you want to move the appointment to another time slot showing on the appointment grid (whether the same provider or not), click the appointment, hold the left mouse button down and drag the cursor to the desired time slot. Release the mouse button.

Deleting an Appointment

There are multiple ways to delete or remove an appointment: click the appointment slot on the appointment grid and press **DELETE**, highlight the appointment in the **Appointment List** and click **Delete**, or right-click on the appointment (either in the **Appointment List** window or on the

appointment grid) and select **Delete** or **Delete item**, respectively. You can also edit the appointment and change the status to **Cancelled**.

F1 Look up Moving/Deleting an Appointment

Patient Recall

NOTE: This is an Office Hours Professional Integrated feature.

The program includes a complete patient recall system with a recall appointment list to assist in contacting patients to schedule appointment dates and times or to make reminder phone calls. This feature is available through both the Medisoft and Office Hours programs.

F1 Look up Patient Recall

Multiple Booking Columns

NOTE: This is an Office Hours Professional feature.

If you want to multi-book appointments (that is, schedule more than one patient in the same time slot), simply right-click the column heading in the appointment grid and the Speed menu gives you a choice of **Add Column** or **Delete Column**. If you add a column, the **Add Column** window has a horizontal scroll bar that lets you indicate the provider for whom you are adding a column. The number of columns determines how many appointments can be booked in one time slot for one provider. There is really no limit as to how many columns can be set up on the appointment grid.

Program Options

Appointment Length

Click **File** and select **Program Options**.

Set the starting and ending appointment times for the practice. Enter the **Starting Time** and **Ending Time**, breaking it down by hour and minutes. Standard appointment **Intervals** can be established by scrolling with the up and down arrows.

You can also set colors to distinguish appointments, breaks, and conflicts (Office Hours Professional). Make decisions concerning all the other default settings in this tab.

Designate one of the reports in the **Speed Report** box (Office Hours Professional) and it automatically prints when you click the Print speed button.

The 'Program Options' dialog box is shown with a blue title bar and a close button (X). It contains the following settings:

- Start Time: 8:00 am
- End Time: 5:00 pm
- Interval: 15 minutes
- Columns: 4
- Default Colors:
 - Appointment: Silver
 - Conflict: Red
 - Break: Gray
- Use enter to move between fields: ☒
- Use Automatic Word Capitalization: ☒
- Automatic Refresh: 8 seconds
- Show Notes on New Appointment: ☒
- Use Automatic Zip Codes: ☒
- Hide Icons in Menus: ☐

Buttons on the right: Save, Cancel, Help.

The following images are from Office Hours Professional.

The 'Program Options' dialog box is shown with the 'Appointment Display' tab selected. It contains the following settings:

- Options | Multi Views | Appointment Display
- Start Time: 8:00 am
- End Time: 5:00 pm
- Interval: 15 minutes
- Default Colors:
 - Appointment: Silver
 - Conflict: Red
 - Break: Gray
- Use Pictures:
 - Break: ☒
 - Repeat: ☒
 - Note: ☒
 - Status: ☒
- Use Enter to Move Between Fields: ☒
- Remind to Save View: ☒
- Use Automatic Word Capitalization: ☒
- Automatic Refresh: 8 seconds
- Show Notes on New Appointments: ☒
- Use Automatic Zip Codes: ☒
- Use Transaction Entry to Make Copays: ☐
- Hide Icons in Menus: ☐
- Speed Report: Quick Appointment List

Buttons on the right: OK, Cancel, Help.

Program Options

Options | Multi Views | Appointment Display

Complete
Dr. Mallard

OK Cancel Help

Edit Delete New

Program Options

Options | Multi Views | Appointment Display

Information to be displayed in the appointment grid

Row 1: Name

Row 2:

Row 3:

Row 4:

Row 5:

OK Cancel Help

Appointment Display

NOTE: This is an Office Hours Professional feature.

In the Appointment Display tab of **Program Options** (click **File** and select **Program Options**), you can specify up to five rows of information to display in the grid for an appointment. Be aware that the length of the appointment determines how much data is actually displayed on the grid. An appointment must be at least 75 minutes long to display five rows of information.

F1 Look up Program Options

Views

NOTE: This is an Office Hours Professional feature.

One of the most important features of the Office Hours Professional program is the variety of ways you can display appointments/breaks in the appointment grid.

At the bottom of the main Office Hours window, in the Status bar, there are four View boxes, with different configurations of dot patterns. These give quick access to the same functions available through the **View** menu. These correspond to Single Provider View, Week View, Month View, or any combination Multi View.

Day View

The Day View shows a single provider's appointments for a selected day. If multiple columns are set up, all columns are displayed. To display another provider's schedule, make a new selection in the provider box in the toolbar. This view does not show columns for resources, but columns can be added or removed as necessary in this view.

Week View

The Week View also shows only one provider's schedule, but with one column for each day of the week. If you have multiple appointments scheduled, the time slot shows the color for scheduling conflicts. You can size the columns to see all the appointments/breaks scheduled by placing the cursor on the right column heading boundary line until it takes the shape of a double-sided arrow, and then drag the boundary line right or left to increase or decrease the size of the column. Columns can be added or removed as necessary in this view.

Month View

The Month View shows up to 31 days, with the boxes colored where appointments have been scheduled. This is a single-provider view. The value of this view is that you can get a good overall view of which days are free for appointments or other scheduled items. Columns cannot be added or removed in the Month View.

Multi View/Multiple Provider/Resource View

The Multi View, or Multiple Provider/Resource View, is the most flexible. The program provides one Multi View setup, which automatically includes all providers and all resources, each with its own column. You can create as many Multi Views as you need in the Multi Views tab of **Program Options**--click **File** and select **Program Options**.

The open data entry field lists all Multi Views that have been set up. This is where you can group providers and/or resources (rooms or facilities scheduled for appointments) in any combination desired, or modify or delete existing multiple view setups. Click **New** to set up a new Multi View (select a view and click **Edit** to make changes).

In the **New View** window, assign a name for the new view. For the first column, indicate the type (Provider or Resource), the **Code** (provider number or resource code), then the width of the column (in pixels). Set up each column you want in the view and click **Close** when finished.

If you want to add a column between columns that have already been created, place your cursor where you want the new column and click **Insert**.

These views can be also edited or reverted to default views through the **View** menu.

Security Setup

If you are using Office Hours in connection with Medisoft, the security settings established in Medisoft are applied to Office Hours as well. However, you can make changes from within Office Hours if needed.

You can be logged in to the program on only one computer at a time. If you are logged in on one computer and try to log in on another, a message pops up. You have to log out of the first computer before you can log in on another computer.

F1 Look up Security Setup

Reports in Office Hours

Reports in Office Hours

If you select one of the following reports in the **Speed Report** box in **Program Options** (Options tab), that report prints automatically when you click the Print speed button (Office Hours Professional). The reports are:

- Quick Appointment List
- Appointment List
- Appointment Grid
- No Show Report

Appointment List

Probably the most important report printed in Office Hours is the Appointment Schedule, a listing of all the day's scheduled events. Generally, printing this report is the first order of business. Print the list and be sure you are ready to meet the day. Go to the Reports menu and select Appointment List.

In the Report Setup window, select how you want the report to print. If you have Office Hours Professional, you can also select if you want to print only those appointments that need referrals.

In the Data Selection window, modify the report by setting Date and Provider ranges, if desired. Remember, if a range is left blank, all available records will be included in the report. See Data Selection Questions.

TIP: If available, select the Print Blank Appointments to include unassigned time slots from the appointment list in the report. Including this data provides flexibility for you to quickly review open slots over the examined range and even print out the report and manually enter patients on the printed report. This feature provides a quick way to accommodate walk in patients when accessing the application is impractical or not desired.

F1 Look up Printing the Appointment List

Appointment Status

NOTE: This is an Advanced and above feature.

The Appointment Status report displays a list of appointments showing their statuses.

F1 Look up Appointment Status Report

Printing Superbills

The superbill is designed to be a physician's worksheet. At the beginning of the day, consider printing a copy of the superbill for each patient with an appointment that day and then attach it to his or her chart. In Medisoft, the superbill is pre-formatted with the patient's name, chart number, appointment time, and the practice name at the top. The superbill displays a list of

what procedures can be performed by the provider and the diagnoses related to it displayed in a list format.

If you use Office Hours integrated with any version of Medisoft, you can print superbills for the day through Office Hours. Go to the **Reports** menu and select **Print Superbills**. In Medisoft select the **Reports** menu and then select **Print Superbills**.

For a discussion on how superbills work and how to track superbills:

F1 Look up How Superbills Work

F1 Look up Tracking Superbills

For more information on creating new superbill report formats, editing an existing Superbill format, or converting an existing superbill format:

F1 Superbills

Deleting a Superbill

If you delete an appointment to which a superbill is attached, the superbill is also deleted from the program. When a numbered superbill is deleted from the program, the number may be released for reassignment. For more information on superbill deletion and reassignment see:

F1 What Happens to the Number When You Delete a Numbered Superbill

Printing a Blank Superbill

This feature allows you to print blank, serialized superbills that are not assigned to an appointment. Before using the feature if you have security applied to your practice, you will need to give access to this feature to appropriate users. The default setting is for level 1 users only. For information on changing permissions:

F1 Look up Permissions

You will also need to select the Force Document Number and Use Serialized Superbills options on the Program Options window, Data tab.

Once enabled, you can print a blank Superbill by selecting the Blank Superbill command on the Reports menu and at a later date, assign the blank superbill to a chart and case in the Transaction Entry. For more information, see:

F1 Printing Blank Superbills

F1 Assigning a Blank Superbill to a Patient and a Case

F1 Look up Printing the Superbill

Running Reports

Reports Overview

Medisoft offers flexible reporting options. You can run reports in Medisoft by selecting various reports from the Reports menu. Or, you can launch the Medisoft Reports engine (for Medisoft Advanced and Medisoft Network Professional only) and complete all reporting tasks in this window. The Medisoft Report window offers several key features not available when running reports off the Reports menu including new reports and features to enhance productivity.

For more information on using the Medisoft Reports engine, see the Medisoft Reports topic. The Medisoft application also supports Medisoft Reports Professional, a robust report authoring application.

F1 Look up Reports Overview

F1 Medisoft Reports Professional

F1 Look up Reports and Printing Reports

Report Designer

One of the most exciting features of Medisoft is the Report Designer, adding flexibility in the creation of reports to best serve your practice or business needs. Using the Report Designer and the existing set of reports, you can generate custom reports tailored to meet specific needs.

Report forms in this section are categorized into several “styles.” Each style defines basic report characteristics, i.e., List, Label, Ledger, Walkout Receipt, Insurance Form, Statement, and Statement Management.

To create custom reports, go to the **Reports** menu and select **Design Custom Reports and Bills**.

F1 Look up Report Designer and Format/Design Reports

Report Procedures

Printing a Report

To print a report, complete the following steps:

1. On the **Reports** menu select the report to be run. The **Print Report Where** window appears.
2. On the **Print Report Where** window, select the **Print the report on the printer** button.
3. Click **Start**. Depending on the report selected, the **Data Selection Questions** window or the **Search** window opens.
4. On the window select data ranges and then click **OK**. The **Print** window appears.
5. Click **OK**.

Viewing a Report

In Medisoft, you can view or preview a report before printing or exporting it. For example, you could preview a Patient Aging report before printing it to make sure that you have selected the most appropriate data criteria. After previewing users can export or print the report.

To view a report, complete the following steps:

1. On the **Reports** menu select the report to be run. The **Print Report Where** window appears.

2. On the **Print Report Where** window, select the **Preview the report on the screen** button. Click **Start**. Depending on the report selected, the **Data Selection Questions** window or the **Search** window opens.
3. On the window select data ranges and then click **OK**. The report is displayed.

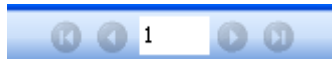
Use the controls in the **Report Preview** window to view or search for details. Controls include:



Print: Used to print the report on the default system printer using the user specified criteria.



Zoom: Used to increase or decrease the viewing size of the report.



Navigate: Used to navigate or browse through the various pages of a multi-page report and features jumping to the first or last page, moving to the previous or next page, or specifying a particular page to view.



Search: Used to further refine data parameters/search criteria. Once you have generated a report, you can further refine the report and search for a more detailed data element. When using this feature, you essentially re-run a report using more specific data criteria.



Close: Used to close the currently displayed report.

NOTE: For some reports that use a different format, such as statements, the controls in this window are slightly different and include a **Save Report to Disk** option. If you select this option, you can save the report in a .QRP format and then use the **Load Saved Reports** command on the Reports menu to load the report.

Searching for a Specific Detail in a Report

Once you have generated a report, you can further refine the report and search for a more detailed data element. When using this feature, you essentially re-run a report using more specific data criteria.

To refine your data criteria and search for specific data:

1. Generate a report.
2. Click the **Search** button.
3. On the **Search** window, select specific data ranges.
4. Click **OK**. The report displays using the new search criteria.

Exporting a Report

In Medisoft, you are able to export a report into another format. For example, you could export a Patient Aging report to an Excel spreadsheet.

To export a report, complete the following steps:

1. On the **Reports** menu select the report to be exported. The **Print Report Where** window opens.
2. Click the **Export the report to a file** button and click **Start**. The **Save As** window appears.
3. On the **Save As window** select a file format for exporting and a destination. Click **Save**. The **Search** window or the **Data Selections Questions** appears (depends on the report or statement selected).
4. On the window select appropriate criteria if needed. Click the **OK** button. The report is exported.

Available Reports

Available Reports

Not only does the program build an accounts receivable file and handle statements, insurance claims, and electronic billing, it also provides a variety of reports that can give you a better understanding of the day-to-day workings of your practice.

Among the reports generated within the program are Day Sheets, Analysis Reports, Aging Reports, Productivity Reports (Network Professional), Activity Reports (Network Professional), Collection Reports (Advanced and above), Audit Reports, Patient Ledger Report, Guarantor Quick Balance List (Network Professional only), and Standard Patient List Reports.

You can print a title page that shows all the filters used in preparing the report.

F1 Look up Program Options.

Day Sheets

Day Sheets are available in three reports. The Patient Day Sheet lists each patient's name, showing all transactions and a summary of activities for the day. The Procedure Day Sheet breaks down by procedure code the activities of the day, summarizing patients treated for each procedure. The Payment Day Sheet shows the payments made on the requested day and the charges to which the payments are applied.

F1 Look up Patient Day Sheet, Procedure Day Sheet, and Payment Day Sheet

Analysis Reports

Billing/Payment Status Report (Advanced and above)

One of the most powerful tools in Medisoft, the Billing/Payment Status Report provides a thumbnail sketch of the current billing and payment status of each claim. The report shows what has been billed and not billed, what is delayed for some reason, if the carrier is not responsible or has refused the claim, or if the claim is paid in full. An asterisk (*) next to an amount indicates that entity has paid all it is going to pay and the balance, if any, should go to the next responsible payer.

F1 Look up Billing/Payment Status Report

Insurance Payment Comparison (Network Professional only)

The Insurance Payment Comparison report compares the payment records of all carriers in the practice.

F1 Look up Insurance Payment Comparison

Practice Analysis

This report summarizes the activity of a specified period (e.g., a month), listing each procedure performed, the number of times it was performed, and the total dollar amount generated by each procedure. It shows the average charge, includes any costs involved with that procedure, and calculates the net monetary effect on the practice's income.

F1 Look up Practice Analysis

Insurance Analysis (Advanced and above)

This report summarizes all claims filed by category (Primary, Secondary, and Tertiary). Claims totals are shown for charges and insurance payments in both dollar amount and percentage.

F1 Look up Insurance Analysis

Referring Provider Report (Advanced and above)

It is good to keep track of the source of your patients. The Referring Provider Report shows which patients were referred by other practices and the percentage each referral contributes to the overall referred income of the practice, as of the date of that report. The report also includes the UPIN of the referring provider. By blanking out the **Referring Provider** range in the **Data Selection Questions** window, a report can be generated showing what percentage of the entire practice has been referred.

F1 Look up Referring Provider Report

Referral Source Report (Advanced and above)

This is another report for tracking the source of patients who come to the practice. For the report to work, however, all referral sources must be entered in the Address Book. A source can be an attorney, a hospital, friends, other patients, or even the Yellow Pages. Most new patient application forms include the inquiry "How did you hear about us?" The Referral Source Report assembles the patient list by source (other than provider) and shows how much revenue comes from each source, allowing the practice to identify those sources that send profitable referrals and/or limit those that are costly or nonproductive.

F1 Look up Referral Source Report

Facility Report (Network Professional only)

This report tracks patients who are seen at different facilities. The Facility Report assembles the patient list by facility and shows how much revenue comes from each facility, helping you identify which generates the most money.

F1 Look up Facility Report

Unapplied Payment/Adjustment Report (Advanced and above)

This report shows any payment or adjustment that has an unapplied amount and where the transaction can be found.

F1 Look up Unapplied Payment/Adjustment Report

Unapplied Deposit Report (Advanced and above)

The Unapplied Deposit Report shows all deposits that have an unapplied amount.

F1 Look up Unapplied Deposit Report

Co-Payment Report (Advanced and above)

The Co-Payment Report shows all patients who have co-payment transactions. It shows the amount of the required co-payment, how much was applied, and what was left unapplied. If a patient does not have any co-payment transactions, he or she is not included in the report.

F1 Look up Co-Payment Report

Outstanding Co-Payment Report (Advanced and above)

This report shows all patients who have outstanding co-payment transactions. The report shows the Co-payment amount expected, the actual amount paid, and the amount due. If a patient has no outstanding co-payment transactions, he or she is not included in the report.

F1 Look up Outstanding Co-Payment Report

Appointment Eligibility Analysis - Detail Report

This report shows patients with appointments whose eligibility has been checked, based on criteria entered. It includes detail about the patients, their appointment date and time, the provider name, and reason code. It is an ARRA report designed for showing that the practice is verifying eligibility electronically.

F1 Look up Appointment Eligibility Analysis - Detail Report

Appointment Eligibility Analysis - Summary Report

This report shows a summary of appointments whose eligibility has been checked, based on criteria entered. It is an ARRA report designed for showing that the practice is verifying eligibility electronically.

F1 Look up Appointment Eligibility Analysis - Summary Report

Electronic Claims Analysis - Detail Report

This report shows the status of claims, providing a summary of total claims and those that have been filed electronically or by paper. It includes the percentage of claims filed electronically. In addition, it shows detail such as the billing date, insurance carrier, sequence, claim number, patient chart and name, and the status of the claim. It is an ARRA report designed for showing that the practice is verifying eligibility electronically.

F1 Look up Appointment Eligibility Analysis - Detail Report

Electronic Claims Analysis - Summary Report

This report shows the status of claims, providing a summary of total claims and those that have been filed electronically or by paper. It is an ARRA report designed for showing that the practice is verifying eligibility electronically.

F1 Look up Appointment Eligibility Analysis - Summary Report

Aging Reports

Patient Aging

One of the important tools in collections is the patient aging report. This can be printed showing the age of each unpaid transaction for patients. Default aging criteria is based upon the number of days between the creation of the transaction or claim and the date of the report you are generating. The columns break down the amounts due that are 30, 60, and 90+ days old. Aging is from actual date of the transaction, so it reflects the true age of the account. The aging criteria and columns can be altered in **Program Options**. This report includes all unapplied amounts in the totals. The Date filter has been removed as it would return invalid values.

F1 Look up Patient Aging

Patient Remainder Aging (Advanced and Network Professional only)

This report has the same format as the Patient Aging, but there is a key difference in how it works. A charge does not show up on Patient Remainder Aging until all insurance responsibility has been marked complete.

F1 Look up Patient Remainder Aging Report

Patient Remainder Aging Detail (Advanced and Network Professional only)

This report has the same criteria as Patient Remainder Aging Detail; however, it also lists each insurance company on the patient's account and the date the insurance payment was marked complete.

F1 Look up Patient Remainder Aging Detail

Insurance Aging and Summary

These reports (Primary, Secondary, and Tertiary) tracks aging of claims filed with insurance carriers. The summary versions are similar but no patient information is included.

F1 Look up Insurance Aging

F1 Look up Insurance Aging Summary

Production Reports

NOTE: This is a Network Professional only feature.

Production by Provider, Procedure, and Insurance and Summary

These reports give incoming revenue information for each provider, procedure, or insurance carrier, respectively. The difference between these reports and the summary versions of the reports is that the summary reports do not display as much detailed information as the regular reports. The summary reports display only a summary of the information available.

F1 Look up Production by... Reports

F1 Look up Production Summary Reports

NOTE: Medisoft Network Professional provides this report on the Reports menu. This report is also available when using the Medisoft Reports Print Engine feature for Medisoft Advanced users.

F1 Look up Medisoft Reports Print Engine

Activity Reports

NOTE: This is a Network Professional only feature.

Daily/Monthly Activity Report

This report presents financial activity based on the date range selected. The report displays the total number and the total amounts of the charges, payments, and adjustments entered during a date range. The report also details the net effect of the financial information entered on the Accounts Receivable balance for the day/month.

Activity Summary by Provider/Insurance and Procedure

Activity reports break down financial activity by day or month. The summary reports summarize financial information entered for each provider/procedure or insurance carrier, respectively.

F1 Look up Activity Reports.

NOTE: Medisoft Network Professional provides this report on the Reports menu. This report is also available when using the Medisoft Reports Print Engine feature for Medisoft Advanced users.

F1 Look up Medisoft Reports Print Engine

Collection Reports

NOTE: This is an Advanced and above feature.

Patient Collection Report

The Patient Collection Report contains information based on statements marked **Sent** in the **Statement Management** window, showing what has not been paid, statement date, etc. Also select Patient Collection Report (Statement Notes) to generate the report with statement notes included.

F1 Look up Patient Collection Report

Insurance Collection Reports

The Insurance Collection Reports are identical in layout, but each reflects the selected insurance level—primary, secondary, or tertiary. This report also shows the claim data, what amount is outstanding, etc. These reports also offer variants that include claim notes.

F1 Look up Insurance Collection Report

Patient Collection Letters

The Collection Letter Report is printed in preparation of collection letters. It contains information from the collection list and is used to help evaluate collections. To access this report, go to the **Reports** menu, select **Collection Reports**, and then **Patient Collection Letters**.

F1 Look up Collection Letter Report

Collection Tracer Report

The Collection Tracer Report reports how many collection letters have been sent and when. Each time collection letters are printed, the program, by default, keeps track of each letter sent.

F1 Look up Collection Tracer Report

Audit Reports

Audit Generator

The Audit Generator helps create a Data Audit Report that contains only the information you want included in the report. The tables available in the Audit Generator are governed by choices made in the Audit tab of the **Program Options** window and whether a table has been edited. You choose which tables, fields, users, and activities are included in the template. This report is intended as a protection for the practice to keep track of changes made and, if desired, by whom.

Some PHI (personal health information) will be included in the Data Audit Report no matter what selections are made or excluded in the **Program Options** window or the Audit Generator.

NOTE: This report does not support printing a report title page even if the **Print Report Title Page** option was set in the **Program Options** window.

F1 Look up Audit Generator

Patient Ledger

This report reflects the account status of each patient. Charges are shown until a payment is entered to remove a specific procedure paid. You may include all patient accounts or select a few. The patient ledger is similar to a ledger card in a manual accounting program. Since the Medisoft program is a true Open Item Accounting program, it can show all or part of the financial activity for a patient, including the current balance and what procedures have not been paid. Past activity in the account includes a listing of all transactions, indicating those that have been paid. The report marks those transactions that have been paid and the amounts.

F1 Look up Patient Ledger

Guarantor Quick Balance List

NOTE: This is a Network Professional only feature.

This report lists the guarantor quick balances that appear in the Quick Balance feature. These balances are the guarantor remainder balances, so if there are charges that the insurance company has not paid on yet, then they are not reflected in this report.

F1 Look up Guarantor Quick Balance List

NOTE: Medisoft Network Professional provides this report on the Reports menu. This report is also available when using the Medisoft Reports Print Engine feature for Medisoft Advanced users.

F1 Look up Medisoft Reports Print Engine

Standard Patient Lists

The Patient by Diagnosis and Patient by Insurance Claim reports provides users a means to sort data in meaningful chunks for analysis and reporting purposes.

F1 Look up Patient by Diagnosis Report

F1 Look up Patient by Insurance Claim Report

Custom Report List

Design capabilities in the program let you generate a variety of custom reports to meet the needs of your practice. To access the customized reports, go to the **Reports** menu and select **Custom Report List**. When you create a customized report, it is included in the Custom Report List.

There are numerous reports already formatted that are included in the program and can be accessed. These include: Address List, Billing Code List, Birthday Card, Birthday Labels, Claim List, Diagnosis Code List, EDI Receiver List, CMS-1500 Forms, Insurance Carrier List, Insurance Payment Tracer (Claim Mgmt), Laser CMS-1500 forms, Patient Birthday List, Patient Face Sheet, Patient List, Patient Recall Labels, Patient Recall List, Patient Statements, Pre-Printed Statement, Primary Claim Detail, Primary Claim Labels, Primary Claim Summary, Procedure Code List, Provider/Staff List, Referring Provider List, Remainder Statements, Remainder Statement Troubleshooter Report, Sample Statement with Image, Sample Statement with Logo, Secondary Claim Labels, Security Permissions Grid, Superbill, Tertiary Claim Labels, Transaction List, Unbilled Transactions, and Walkout Receipts.

TIP: In Medisoft Advanced and Medisoft Network Professional, there are two statement types: Statement and Statement Management. If you are modifying a statement, make sure you are modifying one with the correct type. You can only print Statement report formats from the **Reports** menu and Statement Management report formats from **Statement Management**.

F1 Look up Modifying an Existing Report

Other Report Functions

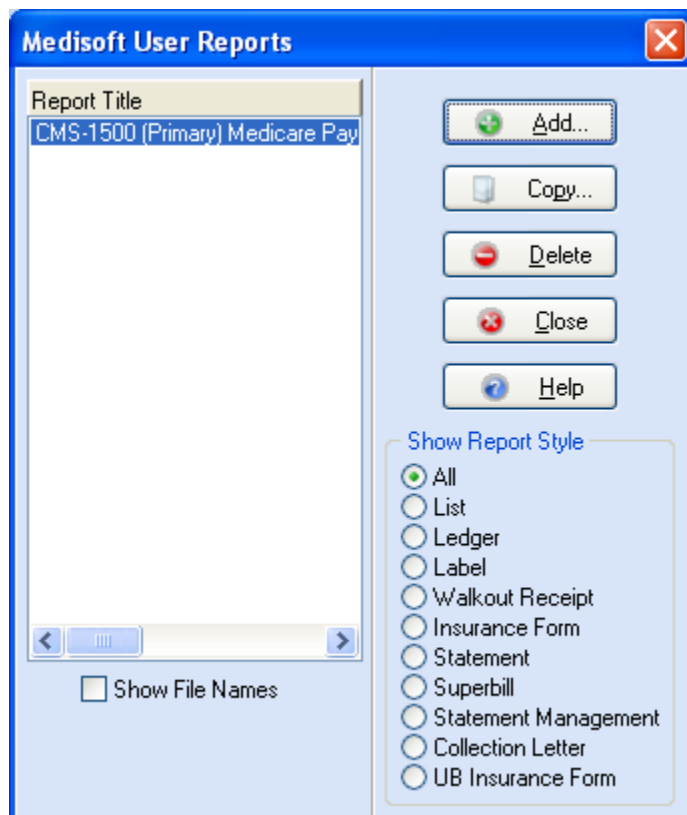
Load Saved Reports

This option allows you to reopen reports that were prepared earlier and have been saved—supports reports and statements that use the .grp extension which is created when an .mre extension report is previewed and saved--mostly statements and custom reports.

F1 Look up Load Saved Reports

Add/Copy User Reports

This option allows you to share reports by adding reports to your database that may have been prepared by another practice or copying reports to disk for use by another practice or for disk storage. Go to the **Tools** menu and select **Add/Copy User Reports**.



NOTE: This function supports reports and statements that use the .mre extension.

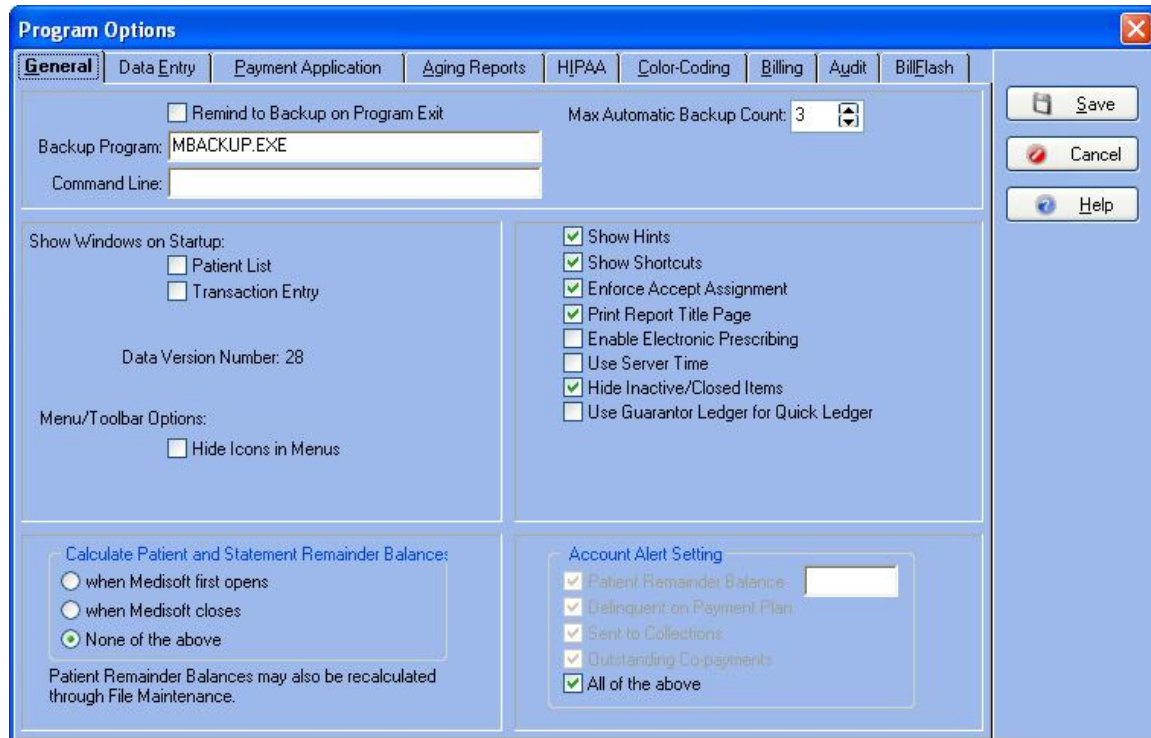
F1 Look up Medisoft User Reports

Available Program Options

General Tab

Backing Up Data

The **General** tab deals with backups, which are an essential part of maintaining a computer-generated billing program, and with general default settings.



TIP: Best Practice--consider backing up data files every day, using a program of rotating backup disks so you can restore lost data to the most recent date before the files were damaged or corrupted. If you are working with multiple practices, each practice should have its own set of backup files. Doing your backups within the Medisoft program is a dependable method.

Consider selecting the Backup Root Data option to back up your root data directory, that is, C:\Medidata. The information backed up can include registration information and other files shared among all your practices. Go to the File menu and select Backup Root Data. The Backup Root Data window opens.

- F1** Look up Backup, View Backup, or Restore
- F1** Look up Backup Root Data

Hide Inactive/Closed Items

Accessed from the General tab on the Program Options window or by right-clicking a list, the Hide Inactive/Closed Items option provides quick filtering options for data display for inactive or closed items. Users can apply a setting on the Program Options tab and as needed, override this setting by right-clicking as needed to view or hide data in a list.

The default setting for this option is not enabled; users can selectively override this setting to enable the feature as needed or permanently change the default setting and then also, as needed, override this setting.

Users can apply these settings to these lists: Address, Billing Codes, Claim Rejection Message, Cases, Contact, Diagnosis Codes, EDI Receiver, Insurance Carriers, Insurance Class, MultiLink, Patient Payment Plans, Procedure Codes, Provider Class, Providers Patients, Referring Providers, and Security Accounts.

When users select the right-click menu option of Show Inactive Records to override the setting on the Program Option window, a red X appears next to all inactive items in the list. The right-click menu also provides an option to Hide Inactive Records.

NOTE: The option that is initially displayed depends on the current setting on the Program Options window. If the feature is enabled on the window, then the right-click menu initially displays the Show Inactive Records option; if the feature is disabled on the Program Options window, then the right-click menu initially displays the Hide Inactive Records option.

NOTE: When providers are marked as inactive in either Medisoft or Office Hours Professional (Provider window, Address tab, Inactive box), their information does not appear on the Appointment grid until the providers' inactive status is updated to active. This means that when in day view (View, Day View), if you select an inactive provider from the Provider drop-down list on the Toolbar and click an appointment timeslot, a message will appear that notes that the provider you selected is inactive. Also, in multi view (View, Multi View) the inactive provider does not even appear on the Appointment grid.

Default Choices

You have the option to show the **Patient List** and/or **Transaction Entry** windows on startup by placing a check mark next to either or both options here. You can indicate whether you want to show shortcuts and/or hints, or **Enforce Accept Assignment**. You have the option to calculate patient remainder balances upon opening or closing the program. You can set account alerts that appear in the Transaction Entry, Deposit List, and Appointment windows that tell you when a patient has a certain remainder balance, is delinquent on a payment plan, or is in collections. In Medisoft Advanced and Medisoft Network Professional, you can indicate whether to print a title page for every report. Network Professional includes an option to synchronize your computer time with the time on the network server.

F1 Look up Program Options-General Tab

Data Entry Tab

The **Data Entry** tab gives you lots of options for various sections of the program.

The screenshot shows the 'Program Options' dialog box with the 'Data Entry' tab selected. The dialog has a blue title bar and a standard Windows-style interface with 'Save', 'Cancel', and 'Help' buttons on the right. The settings are organized into several sections:

- Global:**
 - ☒ Use Enter to move between fields
 - ☒ Use zip code to enter city and state
 - ☒ Suppress UB04 fields
 - Number of Diagnosis:
- Patient:**
 - ☐ Use numeric chart numbers
 - ☒ Auto format Soc. Sec. #
 - ☐ Use Quick Entry for New Patient/Case F8
 - ☐ Use Quick Entry for Edit Patient/Case F9
 - Patient Quick Entry Default:
- Transaction:**
 - ☐ Force Document Number
 - ☒ Force payments to be applied
 - ☒ Multiply units times amount
 - ☐ Auto Create Tax Entry
 - ☐ Use Serialized Superbills
 - ☐ Suppress Co-pay Message
 - Case Default:
 - Default Place of Service Code:
 - Default Tax Code:
- EDI:**
 - ☐ Mark zero payments complete
 - ☐ Separate remittance files
 - ☒ Automatically calculate blank PIN qualifiers
- Date of Deposit:**
 - ☒ Today's Date
 - ☐ Remittance Date
 - ☐ Prompt for Date
- Work Administrator:**
 - ☒ Edit task when created by a rule

In the **Global** section, you can indicate whether to use **ENTER** as a toggle to move between fields, to force payments to be applied, and to multiply unit times amount. Using the zip code to enter city and state information can save a lot of time. When the **Suppress UB04 Fields** check box is selected, UB-04 fields do not appear throughout the program. If you do not process UB-04 claims, check the box. If you do process UB-04 claims, uncheck the box so that all the fields you need to populate the claim form will be available. For more information on UB-04 functionality in Medisoft:

F1 Look up UB-04

In the **Patient** section, you can choose to use numeric Chart numbers (the default is to use an alphanumeric code) and/or have the program automatically hyphenate Social Security Numbers. The **Patient Quick Entry Default** list and the **Use Quick Entry for New Patient/Case F8** and **Use Quick Entry for Edit Patient/Case F9** check boxes provide setting options for the Patient Quick feature, which provides a custom method for creating records. For more information on the Patient Quick Entry feature in Medisoft:

F1 Look up Patient Quick Entry

Choices in the **Transaction** section primarily affect **Transaction Entry**.

Check the Force Document Number to apply a document number to each transaction in Transaction Entry. It forces the Documentation Number field to appear. If you uncheck this option, no document number is applied to the transactions and the Document Number field is not displayed in the Transaction Entry window. If this option is unchecked, the serialized superbill function is also disabled. Selecting this option along with the Use Serialized Superbill box, also provides the option to print blank superbills. For more information on this feature, see:

F1 Printing Blank Superbills

F1 Assigning a Blank Superbill to a Patient and a Case

Use Serialized Superbills: Click this box to use the serialized superbills feature. For more information, see:

F1 Tracking Superbills

If you click **Force payments to be applied**, the program makes you apply every payment before exiting **Transaction Entry**. If you choose to **Multiply units times amount**, the program automatically adjusts the cost of the procedure based on number of units. If you click **Auto Create Tax Entry**, the program automatically adds tax to any selected procedure code that has been marked taxable and creates a separate line item in **Transaction Entry**. Be sure you have created and selected a **Default Tax Code**.

Select the **Suppress Co-pay Message** option to suppress the co-pay collection message on the Transaction Entry for cases that require a co-pay.

The **Case Default** field determines which case is selected in **Transaction Entry**. The default is **Last Case Used**, but you can change this to **Newest Case** or **Oldest Case**.

There is also a field where you can set the default Place of Service Code. The default in this field is 11. When there is an occasional change of location, simply type the new code to override the default entry.

F1 Look up Program Options-Data Entry Tab

Payment Application Tab

NOTE: This is an Advanced and above feature.

In the **Payment Application** tab, you can establish default settings that affect the payment application function.

The screenshot shows the 'Program Options' dialog box with the 'Payment Application' tab selected. The dialog has a blue title bar and a standard Windows-style interface with 'Save', 'Cancel', and 'Help' buttons on the right.

Payment Application Tab Settings:

- ☒ Mark Paid Charges Complete
- ☒ Calculate Disallowed Adjustment Amounts
- ☒ Mark Completed Claims Done
- ☐ Calculate Allowed Amount
- ☒ Update Allowed Amount

Default Patient Payment Codes:

Payments		Co-payments	
Cash: CASH	Cash Payment-Thank You!	COPAYCASH	Cash Copayment
Check: CHECK	Personal Check Payment	CHKCOPAY	Copay Check
Credit Card: CRDCPAY	Credit Card Payment	CRDCOPAY	Copay Credit Card
Adjustment: WROFF	Insurance Write-Off		

Small Balance Write-off:

Patient Write-off Code: SBWO Small Balance Write Off

Maximum Write-off Amount: \$5.00

If you choose to accept the default settings, any amount applied to a charge is automatically marked as paid by that particular payee, the allowed amount is automatically calculated, and

the difference between the calculated allowed amount and the practice charge is offset in the **Adjustment** column. In addition, any claim that has received payment from all responsible payers is automatically marked "Done."

In the lower half of the window, select default billing codes to be applied when using this feature.

F1 Look up Program Options-Payment Application Tab

Aging Reports Tab

The **Aging Reports** tab lets you alter the starting date for patient aging reports and to redefine aging columns for both patient and insurance aging reports.

The screenshot shows the "Program Options" dialog box with the "Aging Reports" tab selected. The dialog has a blue title bar and a tabbed interface. The tabs are: General, Data Entry, Payment Application, **Aging Reports**, HIPAA, Color-Coding, Billing, Audit, and BillFlash. The "Aging Reports" tab is active and contains two main sections: "Patient Aging" and "Insurance Aging".

Patient Aging

Age By:

- ☒ Transaction date from
- ☐ Date of first statement

Aging Columns (Days)

0	to	30
31	to	60
61	to	90
91	to	91 +

Insurance Aging

Aging Columns (Days)

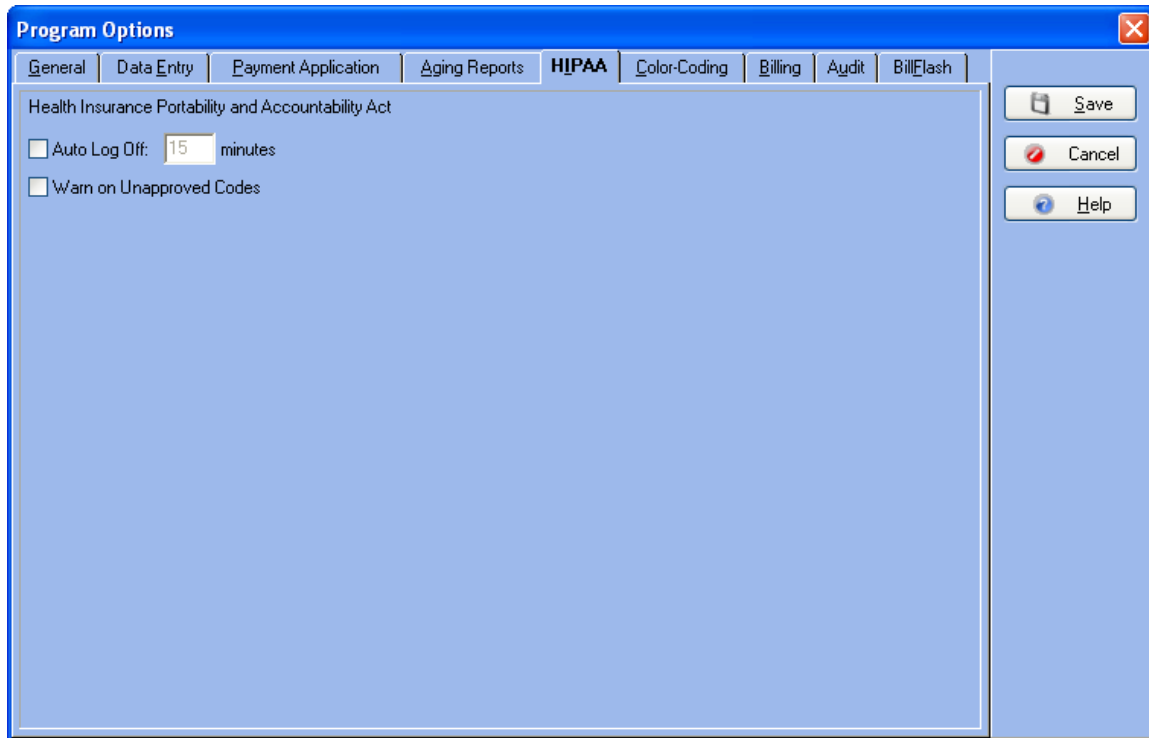
0	to	30
31	to	60
61	to	90
91	to	120
121	to	121 +

On the right side of the dialog, there are three buttons: "Save", "Cancel", and "Help".

F1 Look up Program Options-Aging Reports Tab

HIPAA Tab

The **HIPAA** tab offers features designed to help protect patient information from unauthorized access.



The **Auto Log Off** check box is designed to protect your data files from unauthorized tampering. Click the check box and then enter a number of minutes (up to 59) in the data box. If you click this box and have not utilized the Security Setup feature in the program, a message pops up telling you that security has to be set up before the backup will function. Click OK to clear the message. See Security Setup for information on setting up security for the program.

With Auto Log Off activated, any time the program remains unused for the amount of time designated, it minimizes to a User Login window which requires reentry of the user's password in order to access the program again. You can also click Close Program to turn the program off completely.

When the **Warn on Unapproved Codes** check box is checked, the program alerts you if a code entered or selected is non-HIPAA compliant. This warning pops up every time you save transactions and the program finds a code that has not been marked HIPAA compliant.

To mark an existing code compliant, you need to edit each code entered in the program, determine its HIPAA compliance and then click the HIPAA Approved box (in both **Procedure Code** and **Diagnosis Code** edit windows).

Another option is to use a program such as Codes on Disk. This program imports current CPT and/or ICD-9 codes with all HIPAA-compliant codes marked. See your local Value-Added Reseller or contact McKesson directly at (800) 333-4747.

Color-Coding Tab

NOTE: This is an Advanced and above feature.

Transactions

If you want to use color coding for transactions in **Transaction Entry** and **Quick Ledger**, click the **Use Color Coding** box.

Select colors for each of six types of transactions: **Unsaved**, **No Payment**, **Partially Paid**, **Overpaid Charge**, **Unapplied Payment**, and **Overapplied Payment**. These colors appear in both windows, letting you know at a glance the status of the transaction.

Patients

This feature, called patient flagging, lets you color code patient records to alert you to various situations when viewing the records the **Patient List**, **Transaction Entry**, **Quick Ledger**, and **Deposit List** windows of Medisoft and the **New Appointment** window in Office Hours (when integrated with Medisoft).

The patient flag colors in the **Program Options** window are fixed and cannot be edited. In the box to the right of a color box, assign your own description to that flag color. To activate the edit boxes, click **Use Flags**.

Patient flags are connected to patient records in the Other Information tab of the **Patient/Guarantor** window as you edit or set up a new patient record.

F1 Look up Program Options-Color Coding Tab.

Billing Tab

NOTE: This is an Advanced and above feature.

Statements

Options in the **Statements** section deal with billing cycles. If you want to use billing cycles when sending statements, click **Use Cycle Billing**. If you choose to use cycle billing, be sure to enter a cycle billing days interval (e.g., every 30 days).

The **Add Copays to Remainder Statements** is used to add missed copays (when patients do not immediately pay their copay), to the patient's Copay Remainder statement.

F1 Look up Tracking Missed Copays

F1 Look up Cycle Billing

The screenshot shows the 'Program Options' dialog box with the 'Billing' tab selected. The dialog has a title bar with a close button (X) and a menu bar with tabs: General, Data Entry, Payment Application, Aging Reports, HIPAA, Color-Coding, Billing (selected), Audit, and BillFlash. The main area is divided into three sections: Statements, Billing Notes, and Quick Formats. On the right side, there are buttons for Save, Cancel, and Help.

Statements:

- ☐ Use Cycle Billing (Cycle Billing Days: 0)
- ☒ Standard Statement Detail Only
- ☒ Remainder Statement Detail Only
- ☐ Add Copay's to Remainder Statements

Billing Notes:

- ☒ Create statement billing notes (Statement Billing Note Code: STATEMENT)
- ☒ Create claim billing notes (Claim Billing Note Code: CLAIM)

Quick Formats:

- ☒ Use Statement Management for Quick Statements
- Receipt: Walkout Receipt (All Transactions)
- Statement: Remainder Statement (0, 30, 60, 90)
- Face Sheet: Patient Face Sheet
- Quick List: (empty dropdown)

Billing Notes

When **Create statement billing notes** is activated, a note is added to statements when printed. Be sure to select a default note in the **Statement Billing Note Code** field.

When **Create claim billing notes** is activated, a Comment transaction line is added in both **Transaction Entry** and **Quick Ledger** whenever a claim is billed. The note includes the carrier name, date billed, claim number, and the name of the provider associated with the claim. Be sure to select a default **Claim Billing Note Code**.

F1 Look up Program Options-Billing Tab

Quick Formats

If the **Use Statement Management for Quick Statements** check box is checked, then the Quick Format options for Statements are the Statement Management statements; otherwise, the list would include the Report option statement formats. Any place that a Quick Statement prints would need to print the appropriate statement type: regular statements or Statement Management statements

The **Receipt** format option is tied to the **Quick Receipt** button in **Transaction Entry**. Select a default quick receipt format here, and that receipt is automatically printed when you click the **Quick Receipt** button in **Transaction Entry**.

You can select a default **Statement** format, which gives you one-button printing of a statement from **Quick Ledger**. When you click **Quick Statement** from either of these windows, the default statement is automatically printed for the selected patient record. If you do not specify a default format here, the first time you click **Quick Statement** from **Quick Ledger**, you are required to select a format.

You can print a **Face Sheet** directly from the patient **Case** window. To set a default form, click the down arrow in the **Face Sheet** field and select one of the options. The selected default form prints each time you click **Face Sheet** in the patient **Case** window.

The **Quick List** provides report options for selecting a default list report for the **Quick List** on the **Patient Quick Entry** window. You can print a quick list directly from the **Patient Quick Entry** window each time you click **Quick List** in the **Patient Quick Entry** window.

F1 Look up Program Options-Billing Tab

Audit Tab

The **Audit** tab lists all tables available in the database. The tables you choose here become those tables available in the Audit Generator when preparing the Data Audit Report. If you deselect MultiLink here, it will not be available in the Audit Generator.

Program Options

General | Data Entry | Payment Application | Aging Reports | HIPAA | Color-Coding | Billing | **Audit** | BillFlash

NOTE: By leaving or unchecking any of the following tables you will be turning off all audits for that table. Perform audits on these tables

Medisoft Tables

	Update	Delete		Update	Delete
Address	☐	☐	Insurance Carriers	☐	☐
Allowed Amount	☐	☐	Multilink	☐	☐
Billing Code	☐	☐	Patient / Guarantor	☐	☐
Case	☐	☐	Patient Recall	☐	☐
Contact	☐	☐	Procedure Code	☐	☐
Custom Case Data	☐	☐	Providers / Referring Providers	☐	☐
Custom Patient Data	☐	☐	Transaction	☐	☐
Deposit	☐	☐	Treatment Plan	☐	☐
Diagnosis	☐	☐	Treatment Plan Procedure	☐	☐
Electronic Receivers	☐	☐			

Office Hours Tables

	Update	Delete
Appointments	☐	☐
Reasons	☐	☐
Resources	☐	☐
Superbills	☐	☐
Wait	☐	☐

☒ ARRA Audit

F1 Look up Program Options-Audit Tab and Audit Report Generator

BillFlash Tab

The BillFlash tab allows you to control some of the information that appears on the statements you send electronically via BillFlash, the web based company that is set up to process electronic statements in Medisoft.

The screenshot shows the 'Program Options' dialog box with the 'BillFlash' tab selected. The dialog has several sections: 'Credit Cards Accepted' with checkboxes for Visa, MasterCard, Discover, and American Express; 'Credit Card Security Code Message' with a text field containing '3-4 Digit Sec. Code'; 'Service Message' with three text fields, the first containing 'For Billing Inquiries Call:' and the second '(800)333-4747'; 'Paper Color' with radio buttons for White, Blue, Red, and Green; 'Print Optional Sections' with checkboxes for Summary and Aging; and 'Statement Messages' with a 'Top:' field and five numbered fields (1-5). On the right side of the dialog are 'Save', 'Cancel', and 'Help' buttons.

Credit Cards Accepted: Select which credit cards your practice selects and they will appear on the printed statements in the top right hand corner of each statement. Also, enter a message for the credit card security code.

Service Message: Enter up to three service messages. These will appear on the statement just below the address of the practice.

Paper Color: Select the color of the paper that you want BillFlash to use when the statements are printed.

Print Optional Sections: Select the checkboxes for Summary and Aging if you want that information to appear at the end of the statement.

Statement Messages: Enter up to six statement messages.

Entering a message in the Top field will place the text at the top of the statement. Other messages will be placed in the Messages section just above the line item detail for the statement. If you leave fields 1-5 empty, the Messages section will not appear at all on the statement.

F1 Look up Program Options-BillFlash Tab

Performing File Maintenance

File Maintenance

The program puts you in the driver's seat by giving you the ability to rebuild indexes, pack data, recalculate patient balances, and purge data. The tools to perform each procedure are contained within separate tabs.

TIP: Each of these file management functions carries the warning that it can take a **long time** to process. Keep that in mind when planning your file maintenance activities.

Rebuild Indexes

The Rebuild Indexes tab provides options to rebuild data indexes and lists the files available for rebuilding. Clicking **All Files** includes them all.

The screenshot shows the 'File Maintenance' dialog box with the 'Rebuild Indexes' tab selected. The dialog has a title bar with a close button. Below the title bar are two tabs: 'Purge Data' and 'Rebuild Indexes'. The 'Rebuild Indexes' tab is active and contains a list of data files with checkboxes next to them. A 'Start' button with a green checkmark and a 'Cancel' button with a red X are on the right. A 'Help' button with a question mark is also on the right. At the bottom of the list is an 'All Files' checkbox.

File Maintenance

Purge Data | Recalculate Balances
Rebuild Indexes | Pack Data

The list below represents the data files used by this program. Place a check mark by each file for which you would like to verify and rebuild. Depending on the size of the file, this process may take a LONG time.

Press START to begin the process.

☐ Address	☐ EDI Receiver	☐ Patient Quick Entry	☐ Security
☐ Allowed Amount	☐ Electronic Remittance	☐ Patient Recall	☐ Statement
☐ Audit	☐ Electronic Remittance Trkng	☐ Payment Log	☐ Superbill Tracking
☐ Audit Detail	☐ Eligibility	☐ Payment Plan	☐ Transactions
☐ Billing Code	☐ Eligibility Verification Status	☐ Physician	☐ Treatment Plan
☐ Billing Practice	☐ Group IDs	☐ Practice	☐ Trigger Control Table
☐ Case	☐ HL7 Trigger	☐ Practice Settings	☐ UB04 Form Fields
☐ Claim	☐ Insurance Carrier	☐ Printer Defaults	☐ Unprocessed Invalid Records
☐ Claims	☐ Insurance Class	☐ Procedure	☐ Unprocessed Transactions
☐ Condition Codes	☐ Login Management	☐ Procedure Plan	☐ User Groups
☐ Contact	☐ MultiLink	☐ Provider Class	☐ Value Codes
☐ Credit Card	☐ Multimedia	☐ Referring Provider	☐ Warehouse
☐ Custom Data	☐ Occurrence Codes	☐ Rejection	☐ Wizard Table
☐ Database Password	☐ Occurrence Span Codes	☐ Repeat Task	☐ Work Administrator
☐ Default	☐ Office Hours	☐ Report Tree	☐ Work List
☐ Deposit	☐ Option	☐ Report Users	☐ Zip Code
☐ Diagnosis	☐ Patient	☐ Revenue Codes	
☐ EDI	☐ Patient Discharge Status	☐ Security	

☐ All Files

Start Cancel Help

Pack Data

Select the Pack Data tab to choose the data files from which you want to remove deleted data. Here again, you can choose one particular set of files or click **All Files** to include them all.

File Maintenance

Purge Data | Recalculate Balances

Rebuild Indexes | **Pack Data**

The list below represents the data files used by this program. Place a check mark by each file for which you would like to verify and rebuild. Depending on the size of the file, this process may take a LONG time.

Press START to begin the process.

☐ Address	☐ EDI Receiver	☐ Patient Quick Entry	☐ Security
☐ Allowed Amount	☐ Electronic Remittance	☐ Patient Recall	☐ Statement
☐ Audit	☐ Electronic Remittance Trknng	☐ Payment Log	☐ Superbill Tracking
☐ Audit Detail	☐ Eligibility	☐ Payment Plan	☐ Transactions
☐ Billing Code	☐ Eligibility Verification Status	☐ Physician	☐ Treatment Plan
☐ Billing Practice	☐ Group IDs	☐ Practice	☐ Trigger Control Table
☐ Case	☐ HL7 Trigger	☐ Practice Settings	☐ UB04 Form Fields
☐ Claim	☐ Insurance Carrier	☐ Printer Defaults	☐ Unprocessed Invalid Records
☐ Claims	☐ Insurance Class	☐ Procedure	☐ Unprocessed Transactions
☐ Condition Codes	☐ Login Management	☐ Procedure Plan	☐ User Groups
☐ Contact	☐ MultiLink	☐ Provider Class	☐ Value Codes
☐ Credit Card	☐ Multimedia	☐ Referring Provider	☐ Warehouse
☐ Custom Data	☐ Occurrence Codes	☐ Rejection	☐ Wizard Table
☐ Database Password	☐ Occurrence Span Codes	☐ Repeat Task	☐ Work Administrator
☐ Default	☐ Office Hours	☐ Report Tree	☐ Work List
☐ Deposit	☐ Option	☐ Report Users	☐ Zip Code
☐ Diagnosis	☐ Patient	☐ Revenue Codes	
☐ EDI	☐ Patient Discharge Status	☐ Security	

☐ All Files

Start Cancel Help

Purge Data

The decision to purge data files should be done only after careful consideration. Data removed cannot be reinstated unless you have a previous backup disk containing the information. You have a choice of purging appointment fields, closed cases, and claims data files. In any case, select the cutoff date to which you want to clear data. All data in the selected file before and including the date specified is deleted.

File Maintenance

Rebuild Indexes | Pack Data

Purge Data | Recalculate Balances

Purging a data file will remove data records from the file that you no longer need. You select the data to be removed by checking the appropriate box, then entering a date. The date entered is a cutoff date.

Closed Cases with outstanding balances will not be purged. All data in the selected file before and including date specified will be deleted.

USE THIS PROCESS WITH CARE!!! Data removed cannot be reinstated.

Press START to begin the process.

☐ Appointment Purge
☐ Claim Purge
☐ Statement Purge
☐ Recall Purge
☐ Purge Closed Cases
☐ Credit Card Purge

Cutoff Dates

NOTE: When purging claims or statements, each claim or statement must also have a "Done" status before it will be removed.

Start Cancel Help

Recalculate Balances

On occasion, account balances or applied amounts may appear to be miscalculated. This option recalculates the selected types of balances.

NOTE: An individual patient's account balance can be recalculated in the **Transaction Entry** window by clicking the **Account Total** amount. Click **OK** in the **Transaction Entry** window and the program begins the process.

To recalculate all account balances, click the **Recalculate Balances** check box. To recalculate all unapplied amounts, click the **Recalculate Unapplied Amount** check box. Click the **Recalculate Patient Remainder Balances** to recalculate all patient remainder balances.

The image shows a Windows-style dialog box titled "File Maintenance" with a blue title bar and a close button (X) in the top right corner. The dialog has a tabbed interface. The "Recalculate Balances" tab is selected, showing a description of the process and three checkboxes. The other tabs visible are "Rebuild Indexes", "Pack Data", and "Purge Data". On the right side of the dialog, there are three buttons: "Start" (with a green checkmark icon), "Cancel" (with a red X icon), and "Help" (with a question mark icon).

File Maintenance

Rebuild Indexes Pack Data
Purge Data **Recalculate Balances**

Recalculate Balances will review every patient's record and recalculate the patient's account balance. Recalculate Unapplied Amount will recalculate the unapplied amount for all payments. Recalculate Patient Remainder Balances will review every patient's record and recalculate the patient's remainder balance. This process can take a LONG time.

Press START to begin the process.

☐ Recalculate Balances
☐ Recalculate Unapplied Amount
☐ Recalculate Patient Remainder Balances

Start Cancel Help

F1 Look up File Maintenance

Tutorial Activities

Tutorial Practice 1 - Program Setup

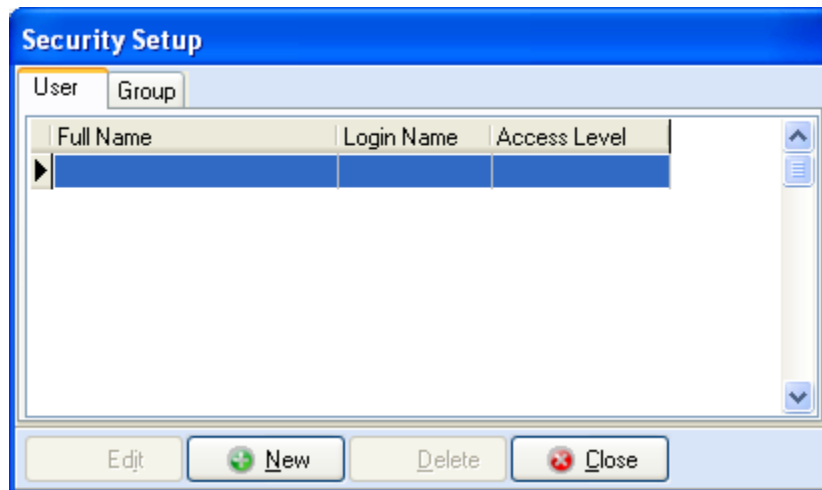
Initial Program Setup

Go to the **File** menu and select **Open Practice**.

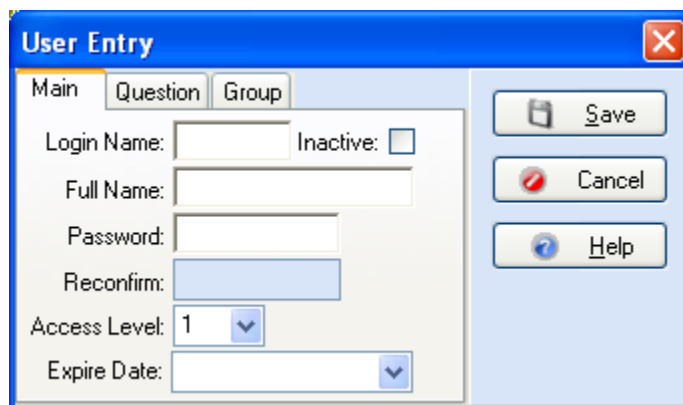
The sample data set up in this tutorial is under the practice name **Medical Group (Tutorial Data)**. Select that name and click **OK**. If this practice name does not appear, click the **Add Tutorial** button. Then select the practice and click **OK**. The practice name appears in the Title bar of the main Medisoft window.

User Setup

1. Go to the **File** menu and select **Security Setup**. This opens the **Security Setup** window.



2. Click **New** to open the **User Entry** window.



3. In the Medisoft original program, we recommend that the first user be designated the Administrator. Click the **Administrator** box in the middle of the window. Then you can

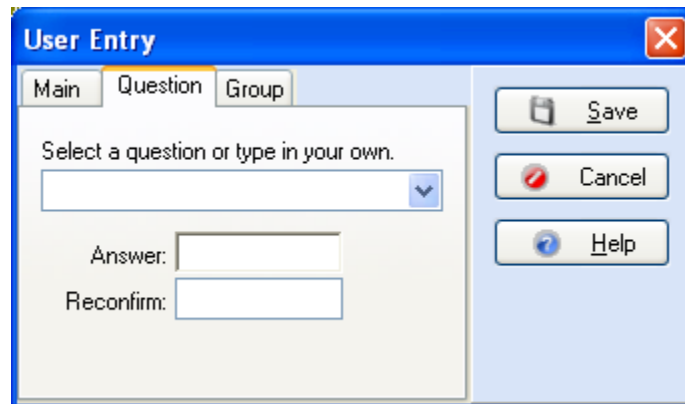
add more names, edit entries, or delete entries as necessary.

In Medisoft Advanced and Medisoft Network Professional, after one Level 1 person has been entered, you can add more names, edit entries, or delete entries as necessary.

4. In Login Name, enter **Supervisor** as the login name.
5. In Full Name, enter **Pat Smith** as the user's full name.
6. In Password, enter **tn872284** as the password.
7. Reenter the password in **Reconfirm**.
8. If you are using Medisoft original, click the Administrator box (if this is the first record you are setting up).

If you are using Medisoft Advanced or Medisoft Network Professional, be sure the **Access Level** is **1**.

9. Skip the Expire Date field for now.
10. Click the **Question** tab.

The screenshot shows a 'User Entry' dialog box with a blue title bar and a close button (X) in the top right corner. Inside the dialog, there are three tabs: 'Main', 'Question', and 'Group'. The 'Question' tab is currently selected. Below the tabs, there is a text prompt 'Select a question or type in your own.' followed by a dropdown menu. Below the dropdown menu, there are two text input fields labeled 'Answer:' and 'Reconfirm:'. To the right of the input fields, there are three buttons: 'Save' (with a floppy disk icon), 'Cancel' (with a red X icon), and 'Help' (with a question mark icon).

11. In the **Select a question or type in your own** field, select **What is your pet's name**.
12. In Answer, type **Ginger**.
13. Reenter **Ginger** in the **Reconfirm** field.
14. Click **Save**.

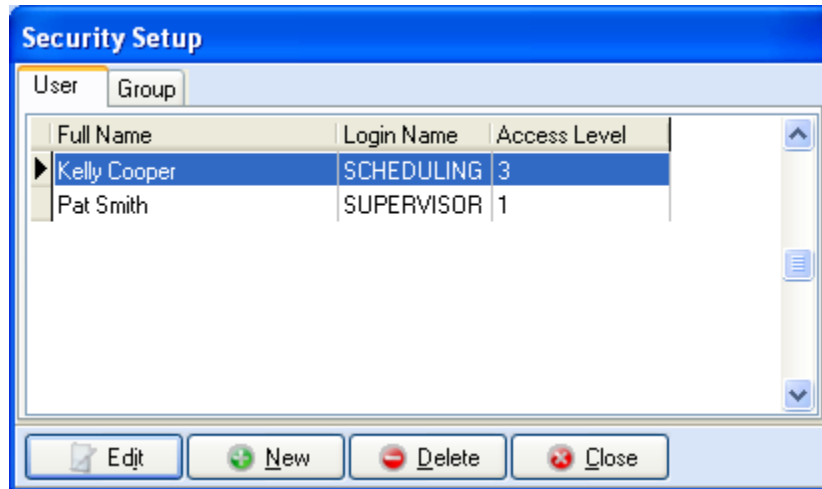
Repeat these steps for a second user only this time, the user will not have the **Administrator** box checked (Medisoft original).

For instance, repeat steps 1-13 to create an entry for Kelly Cooper a login name of scheduling with an access level of 3.

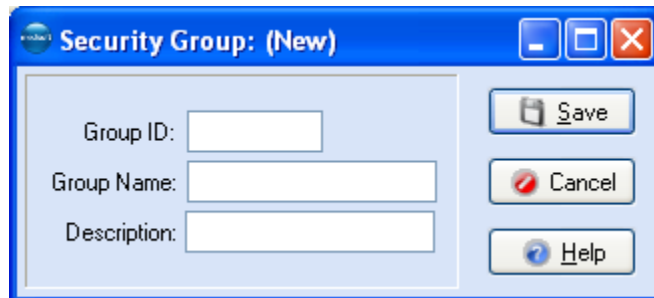
15. Click **Close** to close the **Security Setup** window.
16. If a message pops up reminding you that user's must relog into the program before the changes take effect, click **OK** to clear this message. Exit Medisoft and login using the Supervisor login.

Group Setup

1. Go to the **File** menu and select **Security Setup**. This opens the **Security Setup** window.



2. Click the **Group** tab.
3. Click **New** to open the **Security Group** window.

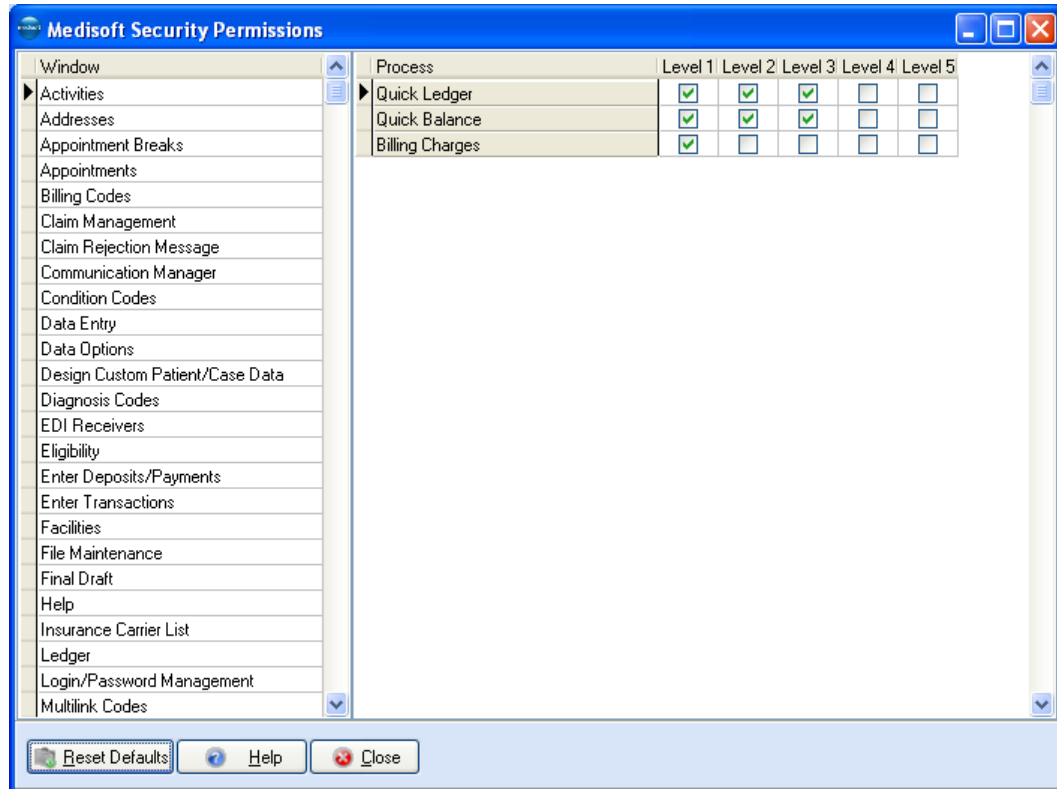


4. In **Group ID**, enter **DCTRS**.
5. Enter **Doctors** in the **Group Name** field.
6. Enter **All doctors and physician assistants** in the **Description** field.
7. Click **Save**.
8. In the **Security Setup** window, click the **User** tab.
9. Select the user information for **Pat Smith**.
10. Click **Edit**.
11. Select the **Group** tab.
12. Click the check-box next to the **DCTRS** group.
13. Click **Save**.
14. Repeat these steps to create another group and to assign a user to that group.
15. Click **Close** to exit the **Security Setup** window.

Permissions

If you are using Medisoft Advanced or Medisoft Network Professional and are logged in as Supervisor (the level 1, Pat Smith user), you can create/revise the rights of each level of security. Be sure you are still in the Tutorial database when you perform the following steps. For this exercise, we will change the settings for Billing Charges function.

1. Go to the **File** menu and select **Permissions**.
2. Select **Activities**. In the **Process** section, give Level 2 and 3 users the rights to Billing Charges by clicking in those boxes.
3. Click **Close**.
4. Click **OK** on the **Information** box.



Login/Password Management

1. Go to the **File** menu and select **Login/Password Management**.
2. Enter **30** in the Renewal Interval field. This way, a password must be replaced every 30 days.
3. In Reuse Period, enter **90** as the number of days before a password can be reused.
4. Enter **6** as the minimum character requirement for a valid password.
5. Enter **25** as the maximum number of characters for a valid password.
6. Click the **Require Alphanumeric** check box. You may notice that the password for the Supervisor already complies with these settings.
7. Enter **5** as the maximum number of failed login attempts before a user is locked out of the program.

8. In Account disable period, enter **5** as the length of time a user's account is on hold when the maximum number of attempts has been exceeded.

Login/Password Management

Password

Renewal Interval: 30 days

Reuse Period: 90 days

Minimum Characters: 6

Maximum Characters: 25

Require Alphanumeric: ☒

Login

Maximum allowed attempts: 5

Account disable period: 5 minutes

Save Cancel Help Reset to Defaults

9. Click **Save**.
10. Close the program and open it again. This applies all the security changes you just set up.
11. When you reenter the program, the **User Login** box appears asking you to enter your login name and password. Enter **Supervisor** and **tn872284**.

Tutorial Practice 2 - Practice Setup

Adding Details to the Practice Record

Go to the **File** menu and select **Open Practice**.

The sample data set up in this tutorial is under the practice name **Medical Group (Tutorial Data)**. Select that name and click **OK**. If this practice name does not appear, click the **Add Tutorial** button. Then select the practice and click **OK**. The practice name appears in the Title bar of the main Medisoft window.

Entering Practice Information

1. Click **File** and select **Practice Information**. Click the **Practice** tab.

2. On the **Practice** tab, you would enter the contact information for practice including practice name, address, telephone number, etc.
3. You would also select from the **Type** list your practice type. Choices include **Medical**, **Chiropractic**, and **Anesthesia**. When you choose Chiropractic or Anesthesia, other areas in the program change accordingly. Medical is the default practice type and does not add any additional fields.

When you select **Chiropractic**, the **Level of Subluxation** field appears in the **Diagnosis** tab of the **Case** window for entering the level of subluxation.

F1 Case Diagnosis

In addition, five treatment fields are displayed in the Miscellaneous tab of the **Case** window electronic claims: **Treatment Months/Years**, **No. Treatments-Month**, **Nature of Condition**, **Date of Manifestation**, and **Complication Ind.**

F1 Case Miscellaneous

Since we are using tutorial data, most of this tab is complete. We will, however, delete and add entries to the Practice IDs grid.

Entering a Practice IDs Grid Entry

You will use the Practice IDs tab and Practice IDs grid to enter or edit key data elements associated with your practice (tax ID/social security number, NPI, taxonomy, legacy numbers, etc).

This grid contains two elements. The first displays all current entries (rules). The second element, the New/Edit Practice ID window, is used to edit or create entries. The grid displays insurance carrier, insurance class, facility, NPI, Taxonomy, tax ID/ social security number and legacy data.

1. Click **Practice IDs** tab.
2. For this activity, the Happy Valley Medical Clinic no longer needs most of their non-NPI identifiers (legacy numbers) at the practice level. The supervisor (Pat Smith) has decided to delete all Practice IDs and enter a general rule for the whole practice along with re-entering the one legacy ID the practice still uses for a certain insurance carrier.

In this case, you could select individual rows on the grid and press the delete key for each row or since we want to delete all the rows, press the **CTRL** key and the **DELETE**

key to delete all grid entries. On the Information window, click **Yes**. All the rows are deleted.

- Now click the **New** button to create a new general rule for the practice.

New Practice ID

☒ All ☐ Provider
☐ Provider Class

☒ All ☐ Insurance Carrier
☐ Insurance Class

☒ All ☐ Facility
☐ None ☒ National Provider ID

☐ None ☒ Taxonomy

☐ None ☒ Tax Identifier

☐ None ☐ Social Security Number

☒ None ☐ Legacy Identifier 1
☐ None ☐ Legacy Identifier 2

ID Qualifier

☒ XX National Provider Identifier
☐ ZZ Provider Taxonomy
☐ Employer Identification Number

- Select the top three **All** buttons.

This selection applies the rule to all providers, all insurance carriers, and all facilities unless you have a more specific grid entry.

- Since Happy Valley Medical Clinic is organized as a group, click the **National Provider ID** button and enter 1234567895.
- Since you file electronic claims and your practice is a group, select the **Taxonomy** button and 998877665Y.

NOTE: setting up taxonomy at the practice level only works if you select the From Practice button for taxonomy on the provider level for each provider and you do not select the Send Practice Taxonomy in Loop 2000A box on the Insurance Carriers window on the EDI/Eligibility tab. Otherwise you will send taxonomy in loop 2000A (solo providers) not loop 2310B (groups).

- Select the **Tax Identifier** button and enter your tax ID: 334455667.
- Select the **None** buttons to not associate legacy numbers with the rule.
- Click **OK**. The rule entry appears on the grid.
- Click **New** to create a second entry for the legacy number for a certain carrier.
- Click the **All** buttons for provider and facility but select the Insurance Carrier button and select **FHP Health Plan** from the lookup window.
- Re-enter your NPI, Taxonomy, and Tax Identifier. Each rule that you create has to be a complete entry by itself.

13. Select the **Legacy Identifier 1** button and enter 44446688 and from the qualifier list select 0B- State License Number.
14. Click **OK**.

The **Practice Information** window displays a table with the following data:

Practice	Practice ID's	Practice Pay-To	Statement Pay-To	Provider	Provider Class	Insurance Carrier	Insurance Class	Facility Code	NPI	Taxonomy Code	Tax ID/SSN	Legacy 1	Legacy 2
All	All	All	All	All	All	FHP00	All	All	1234567895	998877665Y	33-4455667	44446688	

Buttons on the right: Save, Cancel, Help. Buttons at the bottom: Edit, New, Delete, Print Grid.

This saves the rule and when you generate claims for FHP, either print or electronic, your state license number will be included.

15. Click **Save** on the **Practice Information** window.

Setting Up a New Insurance Carrier Record

1. Click **Lists** and select **Insurance** and **Insurance Carriers**. Click **New**.
2. Skip the **Code** field. Enter the following information:
3. In the **Name** field, enter **A1 Insurance Partners**. In the other appropriate fields, enter PO Box 11223, Hartford, CT 01234.
4. Enter **Best Choice** in the **Plan Name** field.

The **Insurance Carrier: A1 Insurance Partners** window shows the following information:

Code: [Redacted] If the Code is left blank, the program will assign one. ☐ Inactive

Carrier Address:

Name: A1 Insurance Partners Phone: [] Extension: []

Street: PO Box 11223 Fax: []

City: Hartford State: CT Contact: []

Zip Code: 01234

Plan Information:

Plan Name: Best Choice Class: []

Note: []

Buttons on the right: Save, Cancel, Help, Set Default.

5. Click the **Options and Codes** tab.
6. Leave the **Procedure Code Set** and **Diagnosis Code Set** fields alone for now.
7. What you select in the various **Signature on File** fields determines what prints in Boxes 12, 13, 31, and 24J of the CMS-1500 form. For now, select **Signature on File** for Patient Signature on File, Insured Signature on File, and Physician Signature on File. Leave blank **Print PINs on Forms**. Leave the **Default Billing Method** as **Paper**.

In the respective default payment application code fields, select **INSPAY**, **APWROFF**, **MCWH**, **DEDUC**, and **TAKEBACK** (for the purpose of this tutorial, we will not create custom default payment types, but use existing ones).

Insurance Carrier: Best Choice

Address Options and Codes EDI/Eligibility Allowed

Options

Procedure Code Set: 1

Diagnosis Code Set: 1

Patient Signature on File: Signature on file Box 12

Insured Signature on File: Signature on file Box 13

Physician Signature on File: Signature on file Box 31

Print PINS on Forms: Leave Blank Box 24J

Default Billing Method 1: Paper

Default Billing Method 2: Paper

Default Billing Method 3: Paper

Default Payment Application Codes

Payment: INSPAY Insurance Payment

Adjustment: APWROFF Aetna Write-Off

Withhold: MCWH Medicaid Withhold

Deductible: DEDUC Deductible

Take Back: TAKEBACK Insurance Takeback

Save Cancel Help Set Default

9. Open the **EDI/Eligibility** tab. Since this tutorial is not dealing with electronic claims, you can skip most of the settings on this tab. In the Type box, select **HMO**.

Insurance Carrier: Best Choice

Address Options and Codes **EDI/Eligibility** Allowed

Primary Receiver

EDI Receiver: [dropdown] [icon]

Claims Payer ID: [text] [icon]

Eligibility Payer ID: [text] [icon]

National Plan ID: [text]

Secondary Receiver

EDI Receiver: [dropdown] [icon]

Claims Payer ID: [text] [icon]

Eligibility Payer ID: [text] [icon]

National Plan ID: [text]

Carrier EDI Settings

Type: **HMO** [dropdown]

Alternate Carrier ID: [text]

NDC Record Code: [text]

EDI Max Transactions: **0** [up/down]

EDI Extra 1/Medigap: [text]

EDI Extra 2: [text]

☐ Complementary Crossover

☐ Delay Secondary Billing

☐ Send Ordering Provider in Loop 2420E

☐ Send Practice Taxonomy in Loop 2000A

Save Cancel Help Set Default

9. Click **Save**.

Setting up a New Provider Record

Dr. Kris Lee has just joined the practice. You will need to set up Dr. Lee's record including creating a general rule for Dr. Lee and also associating a specific insurance carrier with Dr. Lee's record.

1. Click the **Lists**, select **Provider**, and select **Providers**. Click **New**.
2. On the **Address** tab, skip the **Code** field. Enter the following information:

Name: Kris Lee

Credentials: MD

Address: 77 Guadalupe Road, Gilbert, AZ 85234

Office number: (123) 443-2584. There are no additional numbers, so leave those fields blank.

This provider is a Medicare participating provider. Click the **Signature on File** check box, then select or enter 4/3/2008 as the **Signature Date**. Click the **Medicare Participating** check box. Enter Dr. Lee's **License Number** as **ZYX1111110**.

Provider: (new)

Address | **Reference** | Provider IDs

Code: If the Code is left blank, the program will assign one. ☐ Inactive

Last Name:

First Name:

Middle Name: Credentials:

Street:

City: State: Zip Code:

E-Mail:

Office: Fax:

Home: Cell:

☒ Signature On File Signature Date:

☒ Medicare Participating License Number:

Save Cancel Help Set Default

The **Reference** tab is mostly used to display converted legacy data for reference only and is not pulled for claims. The only setting on this tab that impacts claim generation is the Provider Class list (for the purposes of this tutorial, we will not set up a provider class).

- Click **Provider IDs** tab. Click **New**. On the **New Provider ID** window, select the **All** buttons for insurance and facility. These choices will make this rule apply to all insurance carriers and facilities unless you create a more specific entry. Since Dr. Lee is a member of a group practice, select the **Group** button.
- Select the **From Practice** buttons for NPI, taxonomy and tax identifier to pull these values from the practice level. Leave **None** select for the other values.

New Provider ID

☒ All ☐ Insurance Carrier

☐ Insurance Class

☒ All ☐ Facility

File Claim As: ☐ Individual ☒ Group

☒ From Practice ☐ National Provider ID

☒ From Practice ☐ Taxonomy

☐ Tax Identifier

☒ From Practice ☐ Social Security Number

☒ None ☐ Mammography Cert

☒ None ☐ Care Plan Oversight

☒ None ☐ Legacy Identifier 1

☒ None ☐ Legacy Identifier 2

☒ None ☐ Legacy Identifier 3

5. Click **OK**. The rule appears on the **Provider IDs** grid.
6. Click **New**. Select the **Insurance Carrier** button and from the list, select **A1 Insurance Partners**. Leave **All** selected for Facility.
7. Since Dr. Lee is currently the only provider that takes this insurance, select the **Individual** button. Select the **National Provider ID** button and enter 1234567892. Select the **Taxonomy** button and enter 987654321s. Select the **Social Security Number** button and enter 678976566. Select the **Legacy Identifier 1** button and enter 11223344. Select the qualifier of **BQ - HMO Code Number**.

New Provider ID

☒ All
☒ Insurance Carrier: A1000
☐ Insurance Class

☒ All
☐ Facility

File Claim As: ☒ Individual ☐ Group
☐ From Practice ☒ National Provider ID: 1234567892
☐ From Practice ☒ Taxonomy: 987654321s
☐ From Practice ☐ Tax Identifier
☐ From Practice ☒ Social Security Number: 678-97-6566

☒ None ☐ Mammography Cert
☒ None ☐ Care Plan Oversight
☐ None ☒ Legacy Identifier 1: 11223344
☒ None ☐ Legacy Identifier 2
☒ None ☐ Legacy Identifier 3

ID Qualifier
 XX National Provider Identifier
 ZZ Provider Taxonomy
 Social Security Number

BQ - HMO Code Number

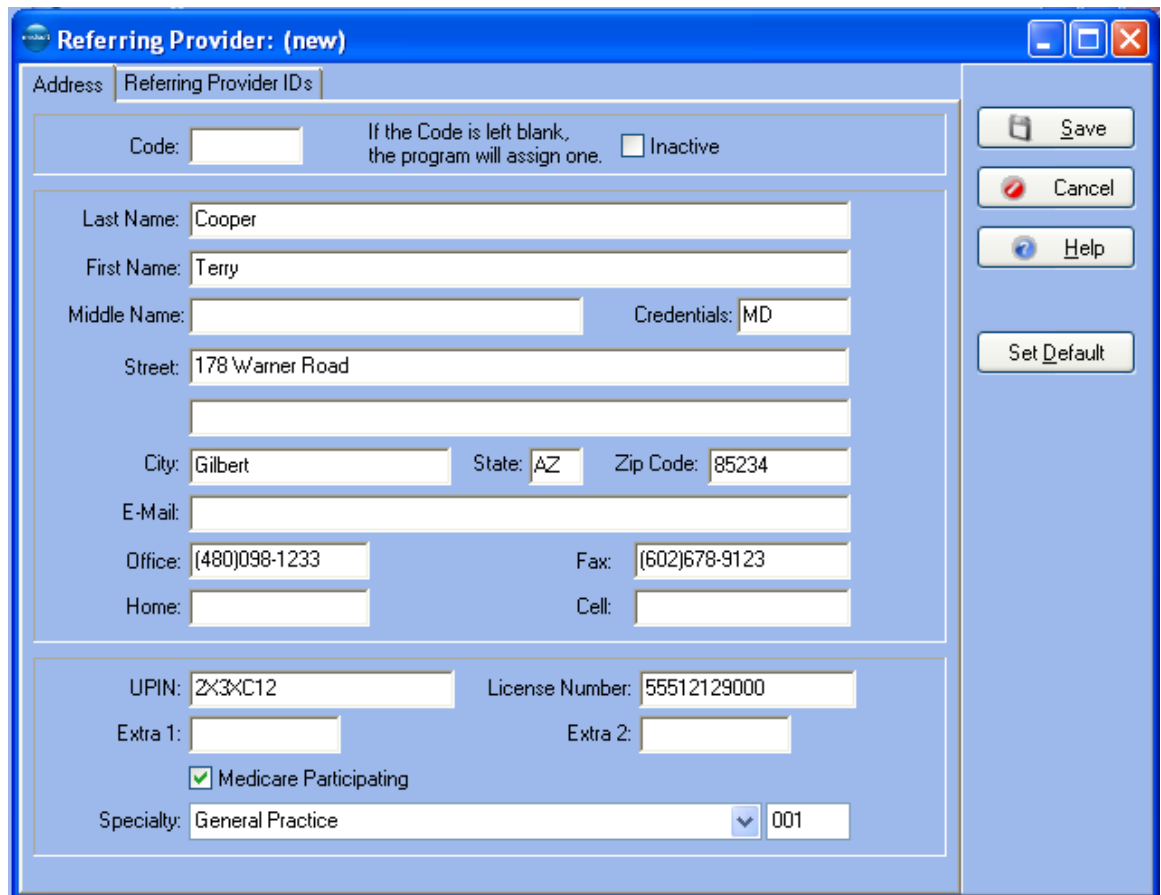
OK
 Cancel
 Help

8. Click **OK**. This rule appears on the grid and when a claim is generated for Dr. Lee that goes to A1 Insurance Partners, these settings will appear on the claim.
9. Click **Save**. Click **Close**.

Setting Up a Referring Provider Record

Dr. Terry Cooper has begun referring patients to your clinic. You will need to create a referring provider record for Dr. Cooper.

1. Click the **Lists** and select **Referring Providers**. Click **New**.
2. On the address tab. Create a record for Terry Cooper, MD; 178 Warner Road, Gilbert, AZ 85234. Enter **tcooper@21medical.com** in **E-Mail** address, **4800981234** in the **Office** phone, **4800981233** as the **Fax**, **6026789123** as the **Home** phone number, and **4805432109** as the **Cell Phone** number. Dr. Cooper is a Medicare participating physician. Also enter **5551212900** in the License Number field and select from the Specialty list, **General Practice**.
3. Dr. Cooper's UPIN is **2X3XC12**. That's all the information needed right now.



The screenshot shows a software window titled "Referring Provider: (new)". It has two tabs: "Address" and "Referring Provider IDs". The "Address" tab is active. The form contains several input fields for provider information. On the right side of the window, there are buttons for "Save", "Cancel", "Help", and "Set Default".

Referring Provider: (new)

Address | Referring Provider IDs

Code: If the Code is left blank, the program will assign one. ☐ Inactive

Last Name: First Name: Middle Name: Credentials:

Street:

City: State: Zip Code:

E-Mail:

Office: Fax:

Home: Cell:

UPIN: License Number:

Extra 1: Extra 2:

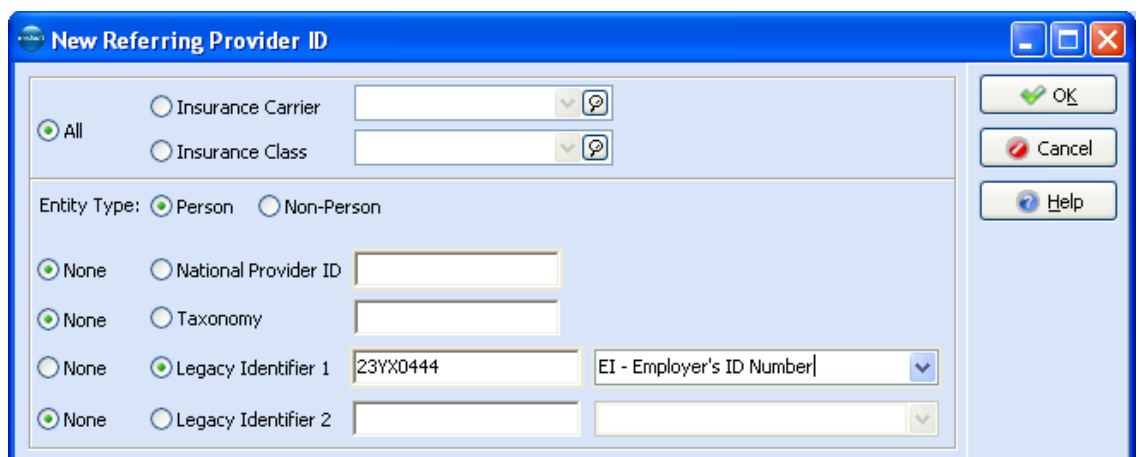
☒ Medicare Participating

Specialty:

Save Cancel Help Set Default

Click the **Referring Provider IDs** tab. Click the **New** button. Click the **All** button for **Insurance**. Click the **Person** button for **Type**. Click the **None** buttons for **National Provider ID** and **Taxonomy**.

- Click the **Legacy Identifier 1** button and enter Dr. Cooper's Federal Tax ID of **23YX0444**. Select the qualifier of **EI - Employer's ID Number**.



The screenshot shows a software window titled "New Referring Provider ID". It contains several radio buttons for selection. On the right side, there are buttons for "OK", "Cancel", and "Help".

New Referring Provider ID

☒ All ☐ Insurance Carrier ☐ Insurance Class

Entity Type: ☒ Person ☐ Non-Person

☒ None ☐ National Provider ID

☒ None ☐ Taxonomy

☐ None ☒ Legacy Identifier 1

☒ None ☐ Legacy Identifier 2

OK Cancel Help

- Click **OK**.

- When information is entered in both tabs, click **Save**. Click **Close**.

Creating a New Address Record

- Click **Lists** and select **Addresses**. The **Address List** window appears. Click **New**.
- Leave the **Code** field blank this time and let the program automatically assign one based on the **Name** field. The code is not assigned until all information is entered and saved.
- In the name and address fields, enter **Pizza Planet**, **1234 Fifth Avenue**, **Anywhere**, **IA 85000**, **1234567890** (this is the phone number). In **Fax Phone**, enter **1234567899**. Be sure the **Type** field reflects **Employer**.
- The contact for this entry is **Murray**.

NOTE: The **Extra 1** and **Extra 2** fields are used for any other information you may want to enter to identify this entry.

- When finished, click **Save**. Click **Close**.

The screenshot shows a software window titled "Address: Pizza Planet". The form is divided into several sections. At the top, there is a "Code" field and a note: "If the Code is left blank, the program will assign one." To the right of this is an "Inactive" checkbox, which is currently unchecked. Below this is a section for the address, containing fields for "Name" (filled with "Pizza Planet"), "Street" (filled with "1234 Fifth Avenue"), "City" (filled with "Anywhere"), "State" (filled with "IA"), and "Zip Code" (filled with "85000"). Below the address section is a section for contact information, containing a "Type" dropdown menu (set to "Employer"), "Phone" (filled with "(123)456-7890"), "Extension" (empty), "Fax Phone" (filled with "(123)456-7899"), "Cell Phone" (empty), "Office" (empty), "Contact" (filled with "Murray"), "E-Mail" (empty), "Extra 1" (empty), and "Extra 2" (empty). On the right side of the form, there are four buttons: "Save", "Cancel", "Help", and "Set Default".

Creating and Editing Procedure Codes

New Procedure Codes

1. Click **Lists** and select **Procedure/Payments/Adjustment Codes**. In the **Procedure/Payment/Adjustment List** window, click **New**.
2. In the General tab, enter **XYZ** in the **Code 1** field, and then enter **Test Code** in the **Description** field. Select **Procedure charge** in the **Code Type** field.
3. The **Account Code** is an internal code for in-house bookkeeping. It can be any configuration of letters or numbers you want to assign to each accounting function, i.e., cash, checks, etc. Enter **OVSP** (for Office Visit-School Patient).
4. Leave **Type of Service** empty. Enter **11** as the **Place of Service**, and leave **Time to do Procedure** empty.
5. Leave the **Service Classification** field alone. It defaults to **A**.
6. Leave the **Alternate Codes** fields alone.
7. Click the **Taxable** box to mark this code as needing tax charges added to it.
8. Click the **Patient Only Responsible** box.
9. No other fields in this window are applicable, so skip them.

Procedure/Payment/Adjustment: Test Code

General | Amounts | Allowed Amounts

Code 1: XYZ ☐ Inactive

Description: Test Code

Code Type: Procedure charge

Account Code: OVSP

Type of Service:

Place of Service: 11

Time To Do Procedure: 0

Service Classification: A

Don't Bill To Insurance:

Only Bill To Insurance:

Default Modifiers:

Revenue Code:

Default Units: 0

National Drug Code:

Code ID Qualifier:

Alternate Codes

2: XYZ

3: XYZ

☒ Taxable ☒ Patient Only Responsible

☐ HIPAA Approved ☐ Purchased Service

☐ Require Co-pay

☒ HCPCS Code

UB HCPCS Code: XYZ

Save Cancel Help

10. Click the **Amounts** tab and enter **50** in field **A** as the amount you want charged for this procedure.
11. Enter **20** in the **Cost of Service/Product** field and **50** in the **Medicare Allowed Amount** field. Click **Save**.

Procedure/Payment/Adjustment: Test Code

General **Amounts** Allowed Amounts

Charge Amounts

A: 50.00	H: 0.00	O: 0.00	V: 0.00
B: 0.00	I: 0.00	P: 0.00	W: 0.00
C: 0.00	J: 0.00	Q: 0.00	X: 0.00
D: 0.00	K: 0.00	R: 0.00	Y: 0.00
E: 0.00	L: 0.00	S: 0.00	Z: 0.00
F: 0.00	M: 0.00	T: 0.00	
G: 0.00	N: 0.00	U: 0.00	

Cost of Service/Product: 20.00 Medicare Allowed Amount: 50

Save Cancel Help

Creating a MultiLink Code

1. Go to the **Lists** menu and select **MultiLink Codes**. Click **New**.
2. In the **MultiLink Code: (new)** window, enter **SCHOOLPHYS** in the **Code** field. Enter a description in the **Description** field, such as **Physical, School**. In **Link Codes 1**, enter **80050**, the general health screen panel; in **Link Codes 2**, enter **81000**, a routine urinalysis; in **Link Codes 3**, enter **93000**, an EKG; and in **Link Codes 4**, enter **99241**, office consultation. When you have selected all of the procedures you want linked, click **Save**. Click **Close**.

MultiLink Code: Physical, School

Code: If the Code is left blank, the program will assign one.

Inactive ☐

Description:

Link Codes

1:	80050	General Health Screen Panel
2:	81000	Urinalysis, Routine
3:	93000	Electrocardiogram-Interp/Rep
4:	99241	Office Consultation FFS
5:	Code 1 Description	
6:	99211	Office Visit Est. Patient MMS
7:	99212	Office Visit Est. Patient FFS
8:	99213	Office Visit Est. Patient EEL
9:	99214	Office Visit Est. Patient DDM
10:	99215	Office Visit Est. Patient CCH
11:	99221	Hospital-Initial E&M DDS
12:	99231	Hospital Visit-Subseq. FFS

Save Cancel Help

Creating a New Diagnosis Code

1. Click **Lists** and select **Diagnosis Codes**. Click **New**.
2. Enter **TEST** in the **Code 1** field. In the **Description** field, enter **Test Diagnosis Code**. Click **Save**. Click **Close**.

Diagnosis: (new)

Code 1:

Description:

Alternate Code Sets

Code 2: Code 3:

☐ HIPAA Approved ☐ Inactive Code

Save Cancel Help

Tutorial Practice 3 - Patient and Case Records

Setting Up a New Patient Record

1. Click **Lists** and select **Patients/Guarantors and Cases**. Click **New Patient**.
2. The **Patient/Guarantor: (new)** window opens on the **Name, Address** tab. **Chart Number** is the first field. Skip this field and let the program create a unique chart number.

3. Create a record with the following information: Name: John Smith Jr; address: 246 Center Street, Gilbert, AZ 85234; e-mail address: johnsmith@gilbertonline.com; home phone number: (513) 224-4668 (remember to not enter parentheses or hyphens in phone numbers); work number: (123) 345-6789; cell phone: (513) 224-1111; fax number: (513) 531-9766; birth date: 1/12/1975; sex: Male; Social Security Number: 012-34-5678; Race: Caucasian; Ethnicity: Non-Hispanic; Language: English.

Patient / Guarantor: Smith, John

Payment Plan: Custom

Name, Address | Other Information

Chart Number: If the Chart Number is left blank, the program will assign one. Inactive ☐

Last Name: Suffix:

First Name:

Middle Name:

Street:

City: State:

Zip Code: Country:

E-Mail:

Home: Work:

Cell: Fax:

Other:

Birth Date: Sex:

Birth Weight: Units:

Social Security: Entity Type:

Race: Ethnicity:

Language: Death Date:

Save Cancel Help Set Default Copy Address... Appointments

4. Click the **Other Information** tab. In the **Type** field, be sure **Patient** is selected. Assign J. D. Mallard as the provider, click **Signature on File**, and enter the signature date of **9/15/2009**.
5. In the **Employer** field, select Bean Sprout Express. Mr. Smith's status is **Full time**. When finished, click **Save**. Click **Close**.

Patient / Guarantor: Smith, John

Payment Plan | Custom |

Name, Address | **Other Information** |

Type: Patient

Assigned Provider: JM J.D. Mallard M.D.

Patient ID #2:

Patient Billing Code: A Default Billing Code

Patient Indicator:

Flag:

Healthcare ID:

Medical Record #:

☒ Signature On File Signature Date: 9/15/2009

Emergency Contact

Name:

Home Phone: Cell Phone:

Default Employment Information for New Cases

Employer: BEA00 BeanSprout Express

Status: Full time

Work Phone: (602)453-9988 Extension:

Location: Retirement Date:

Save Cancel Help Set Default Copy Address... Appointments

Opening a New Case

1. Click **Lists** and select **Patients/Guarantors and Cases**. Select John Smith in the left section of the window. Then click the **Case** button at the top right of the window. Click **New Case**.
2. Enter **Back pain** as the description of this case. Change **Marital Status** to **Single**. All the other information is taken from the patient record.

Case: SMIJ0000 Smith, John [Back pain]

Miscellaneous | Medicaid and Tricare | Comment | EDI | Custom One | **Personal** | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | Condition

Case Number: 0

Description: Back pain ☐ Cash Case
 Global Coverage Until: ☒ Print Patient Statement
 Guarantor: SMIJ0000 Smith, John
 Marital Status: Single Student Status:

Employment
 Employer: BEA00 BeanSprout Express
 Status: Full time
 Retirement Date: Work Phone: (602)453-9988
 Location: Extension:

Patient Information
 Name: Smith, John Home Phone: (513)224-4668
 Address: 246 Center Street Work Phone: (123)345-6789
 Gilbert, AZ Cell Phone: (513)224-1111
 85234 Date of Birth: 1/12/1975

Save Cancel Help UB04... Eligibility... Face Sheet Set Default

Case

- Open the **Account** tab.
- In the **Assigned Provider** field, select Kris Lee. In **Referring Provider**, select **Terry Cooper**.
- Mr. Smith was also referred by another patient. In **Referral Source**, select **Patient Referral**.
- You have already received information from Mr. Smith's insurance carrier and you know that treatment is authorized through February 15. Enter 2/15/2010 in the **Treatment Authorized Through** field. In **Authorization Number** enter **6489211**, in **Authorized Number of Visits** enter **12**, and in the **ID** field, enter **A**.

Case: SMIJ0000 Smith, John [Back pain]

Miscellaneous | Medicaid and Tricare | Comment | EDI | Custom One |
Personal | **Account** | Diagnosis | Policy 1 | Policy 2 | Policy 3 | Condition |

Assigned Provider: KL Kris Lee MD
Referring Provider: C0000 Terry Cooper MD
Supervising Provider:
Operating Provider:
Other Provider:
Referral Source: PAT00 Patient Referral
Attorney:
Facility:

Case Billing Code: A Default Billing Code
Price Code: A Other Arrangements:

Treatment Authorized Through: 2/15/2010

Visit Series
Authorization Number: 6489211 Last Visit Date:
Authorized Number of Visits: 12 ID: A Last Visit Number: 0

Patient Information
Name: Smith, John Home Phone: (513)224-4668
Address: 246 Center Street Work Phone: (123)345-6789
Gilbert, AZ Cell Phone: (513)224-1111
85234 Date of Birth: 1/12/1975

Save
Cancel
Help
UB04...
Eligibility...
Face Sheet
Set Default

Case

7. Open the **Diagnosis** tab.
8. In **Principal Diagnosis**, enter **724.2**.

Case: SMIJ0000 Smith, John [Back pain]

Miscellaneous | Medicaid and Tricare | Comment | EDI | Custom One |

Personal | Account | **Diagnosis** | Policy 1 | Policy 2 | Policy 3 | Condition |

Principal Diagnosis: 724.2 [v] [?] Low Back Pain POA ☐

Default Diagnosis 2: [] [v] [?]

Default Diagnosis 3: [] [v] [?]

Default Diagnosis 4: [] [v] [?]

Allergies and Notes
allergic to penicillin

EDI Notes

EDI Report
Report Type Code: [] Report Transmission Code: []
Attachment Control Number: []

Patient Information
Name: Smith, John Home Phone: (513)224-4668
Address: 246 Center Street Work Phone: (123)345-6789
Gilbert, AZ Cell Phone: (513)224-1111
85234 Date of Birth: 1/12/1975

Save Cancel Help

UB04... Eligibility... Face Sheet Set Default

Case [] [v] [?]

9. Open the **Condition** tab.
10. In the Injury/Illness/LMP Date field enter January 15, 2010, the **Illness Indicator** is **Injury**. There have been no similar symptoms. This was not related to an auto accident, so select **No** in the **Related To** field. In **Nature Of**, select **Injured during recreation**. No other fields are important for this case so leave them blank.

Case: SMIJ0000 Smith Jr, John [Back pain]

Miscellaneous | Medicaid and Tricare | Multimedia | Comment | EDI | Custom One

Personal | Account | Diagnosis | Policy 1 | Policy 2 | Policy 3 | **Condition**

Injury/Illness/LMP Date: 1/15/2010 Date Similar Symptoms:

Illness Indicator: Injury

Initial Treatment Date:

☐ Same/Similar Symptoms
☐ Employment Related
☐ Emergency

Accident

Related To: State:

Nature Of: Injured during Recreation

Last X-Ray Date:

Death/Status

Dates

	From	To
Unable to Work:		
Total Disability:		
Partial Disability:		
Hospitalization:		

Workers' Compensation

Return To Work Indicator:

Percent of Disability:

Last Worked Date:

☐ Pregnant

Estimated Date of Birth:

Date Assumed Care:

Date Relinquished Care:

Condition Codes

1.	2.	3.	4.	5.	6.
7.	8.	9.	10.	11.	12.

Patient Information

Name: Smith Jr, John Home Phone: (513)224-4668
Address: 246 Center Street Work Phone: (123)345-6789
Gilbert, AZ Cell Phone: (513)224-1111
85234 Date of Birth: 1/12/1975

Case: 22

Save Cancel Help Eligibility... Face Sheet Set Default

11. Open the **Policy 1** tab.
12. In **Insurance 1**, select **A1 Insurance Partners**. Mr. Smith's **Policy Number** is **9782XYZ**, and his **Group Number** is **98KEY**. The **Policy Start** date is **January 1, 2010** and the **End** date is **December 31, 2010**. Click **Assignment of Benefits/Accept Assignment**. Leave the default information in the rest of the fields in this tab.

Case: SMIJ0000 Smith Jr, John [Test]

Miscellaneous | Medicaid and Tricare | Multimedia | Comment | EDI | Custom One
 Personal | Account | Diagnosis | **Policy 1** | Policy 2 | Policy 3 | Condition

Insurance 1: A1000 A1 Insurance Partners
 Policy Holder 1: SMIJ0000 Smith Jr, John
 Relationship to Insured: Self
 Policy Number: 9782XYZ
 Group Number: 98KEY
 Group Name:
 Claim Number:

Policy Dates
 Start: 1/1/2010
 End: 12/31/2010

☒ Assignment of Benefits/Accept Assignment
☐ Capitated Plan
 Deductible Met: ☐
 Annual Deductible: 0.00
 Copayment Amount: 0.00

Treatment Authorization:
 Document Control Number:

Insurance Coverage
 Percents by Service
 Classification

A:	80	C:	0	E:	80	G:	80
B:	100	D:	80	F:	80	H:	80

Patient Information
 Name: Smith Jr, John
 Address: 246 Center Street
 Gilbert, AZ
 85234
 Home Phone: (513)224-4668
 Work Phone: (123)345-6789
 Cell Phone: (513)224-1111
 Date of Birth: 1/12/1975

Save
 Cancel
 Help
 UB04...
 Eligibility...
 Face Sheet
 Set Default

Case
 22

13. Mr. Smith has a secondary insurance policy. Open the **Policy 2** tab. Select **FHP Health Plan** as his secondary coverage, Policy Number **00034526Z**, and the Group Number is **888B**. Policy **Start** and **End** dates are **January 1, 2010** and **December 31, 2010**, respectively. Click **Assignment of Benefits/Accept Assignment**. Your carrier assigns a Claim Number; for this example, use **283-8765D**.

Case: SMIJ0000 Smith, John (new)

Miscellaneous | Medicaid and Tricare | Multimedia | Comment | EDI | Custom One
 Personal | Account | Diagnosis | Policy 1 | **Policy 2** | Policy 3 | Condition

Insurance 2: FHP00 FHP Health Plan
 Policy Holder 2: SMIJ0000 Smith Jr, John
 Relationship to Insured: Self
 Policy Number: 000345262
 Group Number: 8888
 Group Name:
 Medicare Secondary Reason:
 Claim Number: 283-8765D

Policy Dates
 Start: 1/1/2010
 End: 12/31/2010

☒ Assignment of Benefits/Accept Assignment
☐ Crossover Claim

Treatment Authorization:

Insurance Coverage
 Percents by Service
 Classification

A:	80	C:	0	E:	80	G:	80
B:	100	D:	80	F:	80	H:	80

Patient Information
 Name: Smith Jr, John
 Address: 246 Center Street
 Gilbert, AZ
 85234
 Home Phone: (513)224-4668
 Work Phone: (123)345-6789
 Cell Phone: (513)224-1111
 Date of Birth: 1/12/1975

Save
 Cancel
 Help
 Eligibility...
 Face Sheet
 Set Default

Case

14. No fields in the Medicaid and Tricare or Multimedia (Advanced and above) tabs are necessary for Mr. Smith--skip these tabs. Click **Save** when finished.

Tutorial Practice 4 - Transactions

Transaction Entry

- To begin, go to the **Activities** menu and select **Enter Transactions**.
- For this exercise, select John Smith in the **Chart** field to pull up Mr. Smith's chart. Press **ENTER**. His most recent case opens.
- To create a new transaction, click any column in the **Charges** section or click **New**. Any information contained in the case **Allergies and Notes** box is popped up for your view. Click **OK** to clear this message and continue.

4. Enter **99214** (Office visit) in the **Procedure** column. Press **ENTER**. All available information concerning that procedure code is automatically entered in the appropriate column. The charge shows \$65 for the visit.
5. To create a second charge transaction, press the down arrow or click **New**. Now enter a second procedure code for this visit, **82954** (Glucose Test). Note that the **Amount** field shows \$10.00.
6. Mr. Smith is making a payment of \$10 on the account. Click any column in the **Payments, Adjustments, and Comments** section, and then enter the procedure code for a cash co-payment (**COPAY10**). In **Who Paid**, select Mr. Smith. In the **Description** field, enter **Co-payment**. Notice that -10 is entered in the **Amount** field. Click **Apply**.
7. The **Apply Payment to Charges** window shows each of the charge entries that have been made and a white column marked **This Payment**.

Apply Payment to Charges

Payment From: G
For: Smith, John

Unapplied
-10.00

Date From	Document	Procedure	Charge	Balance	Payor Total	This Payment
2/1/2010	1002010000	99214	65.00	65.00	0.00	0.00
2/1/2010	1002010000	82954	10.00	10.00	0.00	0.00

There are 2 charge entries.

8. With the \$10 to apply, select the charge that is \$65.00, click in the **This Payment** column of that transaction, and enter **10**.
9. Click **Close**.
10. You need to make an adjustment, so click **New** in the **Payments, Adjustments, and Comments** section of **Transaction Entry**. Enter the adjustment code **CACSYDISC**, in the **Pay/Adj Code** field, **Courtesy Discount** in the **Description** column, and **5** as the adjustment amount. Click **Apply**.
11. The **Apply Adjustment to Charges** window is similar to the **Apply Payments to Charges** window.
12. Locate the \$55 balance and enter **5** in the **This Adjust** column. Click **Close** to return to the **Transaction Entry** window.

Transaction Entry

Chart: SMUJ0000 Smith, John (1/12/1975)

Case: 20 Back pain

Charges: RB

Last Payment Date:
Last Payment Amount: \$0.00
Last Visit Date:
Visit: 0 of A 12
Global Coverage Until:

A1 Ins.. FHP He.. Patient

Co-pay Overdue: \$0.00

0-30	31-60	61-90	91+
0.00	\$0.00	\$0.00	\$0.00

Total: \$0.00

Policy Copay: 0.00 OA: YTD: \$0.00
Annual Deductible: 0.00

Charges: \$0.00
Adjustments: \$0.00
Subtotal: \$0.00
Payment: \$0.00
Balance: \$0.00
Account Total: \$0.00

Date	Procedure	PP	Units	Amount	Total	Diag 1	Diag 2	Diag 3	Diag 4	1	2	3	4	Provider	POS	TOS	Allowed	Unapplied
2/1/2010	99214		1	65.00	65.00	724.2								KL	11	1	0.00	
2/1/2010	82954		1	10.00	10.00	724.2								KL	11		0.00	

New Delete MultiLink Note Details Total Taxable Amount: 0.00 Tag

Payments, Adjustments, And Comments:

Date	Pay/Adj Code	Who Paid	Description	Provider	Amount	Check Number	Unapplied
2/1/2010	COPAY10	Smith, John -Guarantor	Co-Payment	KL	-10.00		\$0.00
2/1/2010	CACSYDISC		Courtesy discount	KL	5.00		\$0.00

Apply New Delete Note

Calculate Totals Update All Quick Receipt Print Receipt Print Claim Close Save Transactions

Transaction Documentation

1. You need to add a note to the first transaction. Locate that transaction in the **Charges** area and click **Note** in that same area. (You can add a note to either a charge transaction or a payment/adjustment transaction.)
2. The default **Type** is **Transaction Note (internal use only)**. Enter the following in the **Documentation/Notes** area of this window: **Follow up with the carrier on this charge.**
3. Press the **ENTER** key and then press **CTRL +T** to enter a date and time stamp in the note. Click **OK**. Click **Save Transactions**. In the column to the right of the selected transaction there is a small icon, which indicates that a note has been added. This indicator is also displayed in the **Quick Ledger** window next to this transaction.

Transaction Documentation

Type: Transaction Note (internal use only)

Documentation/Notes

Follow up with carrier on this charge
2/2/2010 9:21:52 AM SUPERVISOR

OK Cancel Help

4. Click **Close** to close the **Transaction Entry** window.
5. Click **Save Transaction**.

Tutorial Practice 5 - Claims

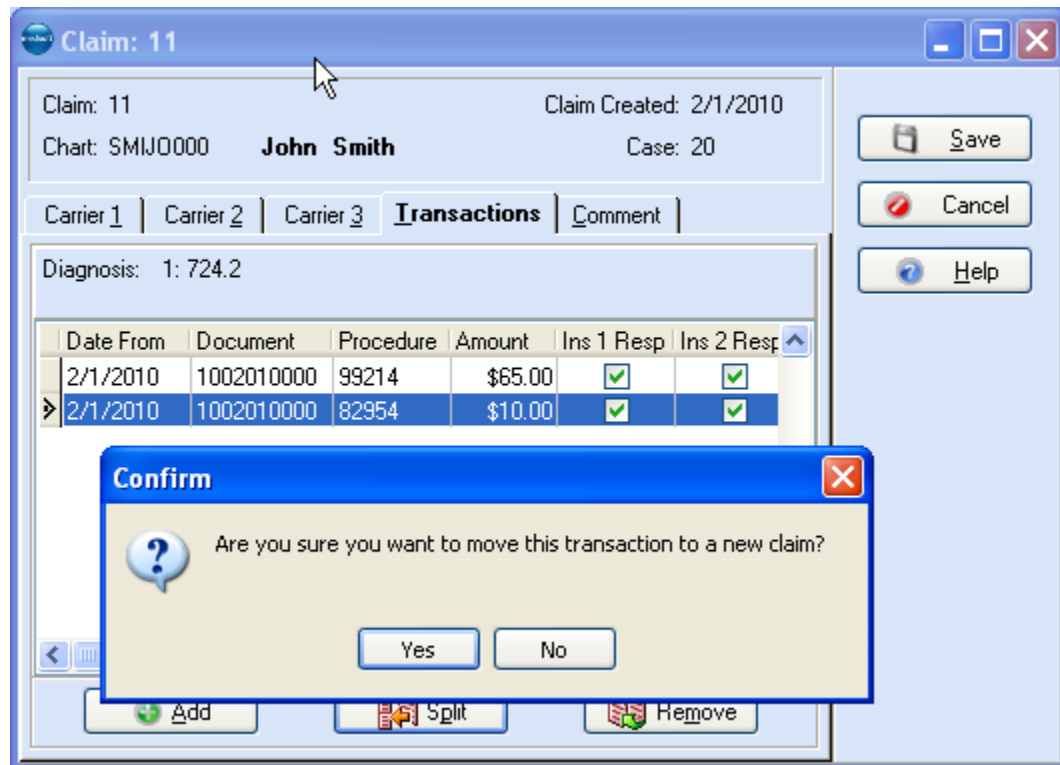
Creating Claims

1. Click **Create Claims** in the **Claim Management** window.
2. Since we created two charge transactions for John Smith in the Transaction Entry portion of this tutorial, let's create the claim for these charges. Click the first **Chart Numbers** range field and type **SMI** to set SMIJ0000 in the first **Chart Numbers** field. Repeat this process in the second **Chart Numbers** field.

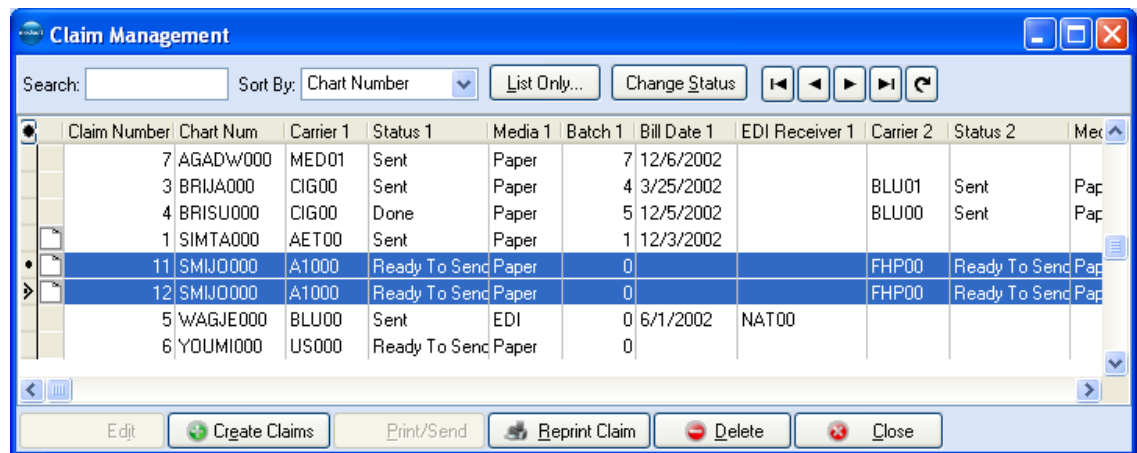
3. Click **Create**.
4. When you return to the **Claim Management** window, change the **Sort By** field to **Chart Number** and type **SMI** in the **Search** field. Press **Enter**. A new claim has been created for SMIJ0000.

Editing Claims

1. To edit the claim, highlight the SMIJ0000 claim and then click **Edit** or press **F9** to open the **Claim** editing window.
2. Open the Comment tab. Type the following message: **Notify attorney when claim is paid by primary carrier**. Press **ENTER** and then press **CTRL+T** to enter a date/time stamp.
3. The two transactions we created in **Transaction Entry** are now part of one claim. Suppose you find out that they have to be sent separately (for whatever reason). Open the **Transactions** tab.
4. This tab shows that both transactions are included in the selected claim. To split the claim, highlight the second transaction, procedure code 82954, and click **Split**. Click **Yes** to split the claim. The second transaction is removed from the claim.

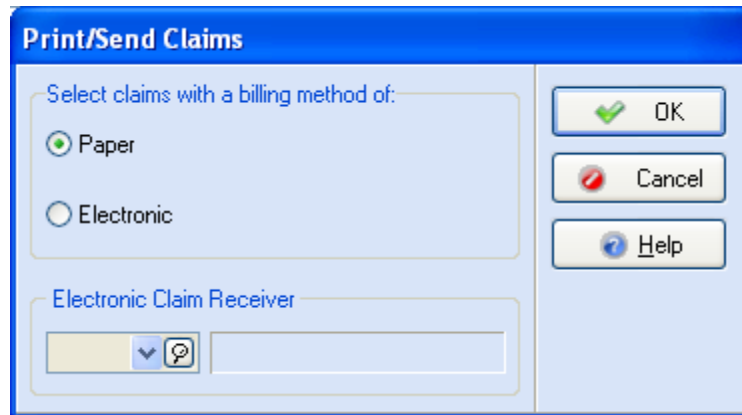


5. Click **Save**. When **Claim Management** is reopened, a second claim has been created and displays below the original claim.



Sending Claims

1. Once the claims are ready to go, in the **Claim Management** window, click **Print/Send** to open the **Print/Send Claims** window.
2. We are dealing only with paper claims in this tutorial, so leave the setting at **Paper** and click **OK**.



3. The **Open Report** window opens so you can select the claim form on which to send the claim. For now, highlight **CMS-1500 (Primary)** and click **OK**.
4. The **Print Report Where?** window pops up for you to indicate whether you want to preview the claim before printing or just send the claim directly to the printer. For now, leave the setting on **Preview the report on the screen** and click **Start**.
5. The program assembles the information and then displays the **Data Selection Questions** window. In each of the **Chart Number Range** fields, select Mr. Smith's chart number. Click **OK**.
6. The claim is displayed in the **Preview Report** window. If you have preprinted CMS-1500 claim forms, put a couple in your printer. Click the Print Report speed button. Answer whatever questions you may need in the **Print** window, and then click **OK**.
7. Click **Close** in the **Preview Report** window. You may briefly see an **Update Billing Status** window and then are returned to **Claim Management** and the claim for Mr. Smith is printed. The claim status has been automatically changed to Sent, a batch number assigned, and the current date entered in the **Bill Date 1** column for both claims.

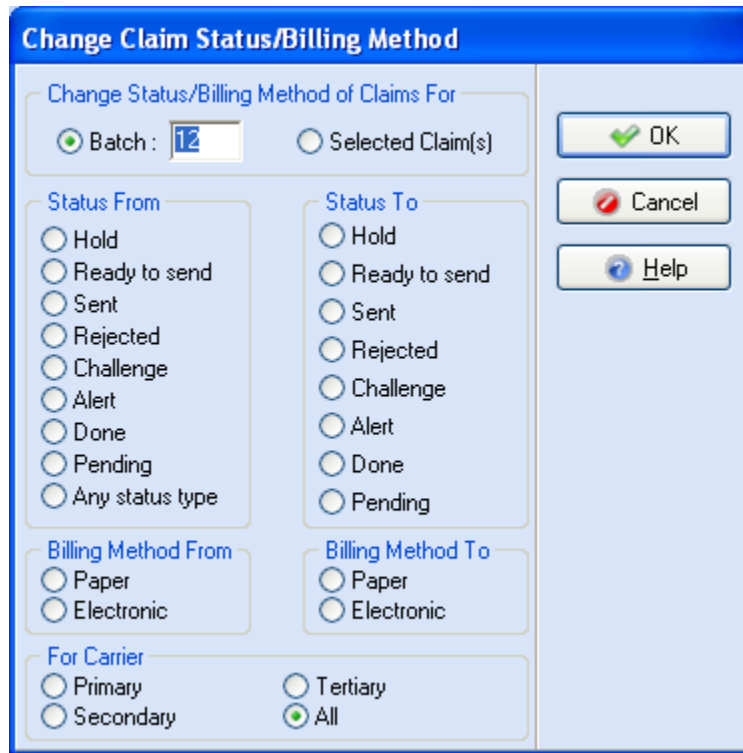
Changing Claim Status

Through **Claim Management**, all submitted claims are automatically marked **Sent** with an indication of the method of submission. The status needs to be changed when the claim is paid completely or if a claim is rejected or put on hold or pending for some reason. Time has passed since you printed and sent the claims for John Smith and you have received a rejection notice from the carrier. You have already corrected the errors and are ready to resend the claims. To locate Mr. Smith's claims, we will use a different portion of the program. Click **List Only** and select John Smith's chart in the **Chart Number** field. Click **Apply**. In **Claim Management**, make note of the batch number and click **Change Status**.

1. Select the **Batch** button and make sure the batch number in the box matches that shown in **Claim Management**.

NOTE: Since we used the **List Only Claims that Match** window to locate the claims, the batch number is automatically entered in the **Change Claim Status/Billing Method** window.

2. In the **Status From** section, choose **Sent**. In the **Status To** section, choose **Ready to Send**.



The dialog box is titled "Change Claim Status/Billing Method". It contains several sections for configuring the change:

- Change Status/Billing Method of Claims For:** Two radio buttons: "Batch:" (selected) with a text box containing "12", and "Selected Claim(s)".
- Status From:** A list of status options: Hold, Ready to send, Sent, Rejected, Challenge, Alert, Done, Pending, and Any status type.
- Status To:** A list of status options: Hold, Ready to send, Sent, Rejected, Challenge, Alert, Done, Pending, and Any status type.
- Billing Method From:** Two radio buttons: Paper and Electronic.
- Billing Method To:** Two radio buttons: Paper and Electronic.
- For Carrier:** Three radio buttons: Primary, Secondary, and All (selected).

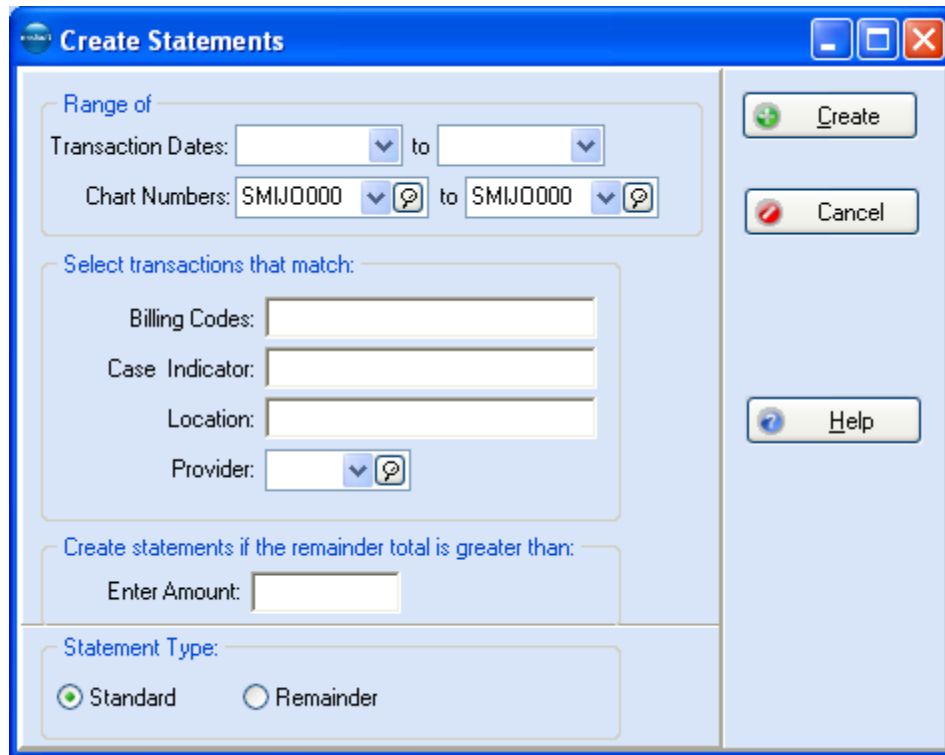
On the right side of the dialog box, there are three buttons: "OK" (with a green checkmark icon), "Cancel" (with a red X icon), and "Help" (with a question mark icon).

3. Click **OK**. You are now ready to send the claims for John Smith again.

Tutorial Practice 6 - Statements

Creating Statements

1. Click **Activities** and select **Statement Management**. Click **Create Statements** in the **Statement Management** window to open the **Create Statements** window.
2. Since we created two charge transactions for John Smith in the Transaction Entry portion of this tutorial, let's create the statement for these charges. Click the first **Chart Numbers** range field and select John Smith's chart. Repeat this process in the second **Chart Numbers** field.
3. Click **Create**.



4. When you return to the **Statement Management** window, a new statement has been created for SMIJ0000.

Editing Statements

1. To edit the statement, highlight the SMIJ0000 statement and then click **Edit** or press **F9** to open the **Statement** editing window.
2. Open the Comment tab. Type the following message: **Notify attorney when statement paid**. Press **ENTER** and then press **CTRL + T** to set a date/time code. Click **Save**.

Statement: 13

Statement Created: 2/1/2010

Guarantor: SMJ0000 **John Smith**

Remainder: \$60.00

General Transactions **Comment**

notify attorney when statement paid

Save Cancel Help

Sending Statements

1. Once the statements are ready to go, in the **Statement Management** window, click **Print/Send** to open the **Print/Send Statements** window.
2. We are only dealing with paper statements in this tutorial, so leave the setting at **Paper** and click **OK**.

Print/Send Statements

Select statement method:

☒ Paper

☐ Electronic

Electronic Statement Type

Exclude Billed Paid Entries ☒

OK Cancel Help

3. The **Open Report** window opens so you can select the statement form on which to send the statement. For now, highlight **NEW Patient Statement (30, 60, 90)** and click **OK**.

4. The **Print Report Where?** window pops up to indicate whether you want to preview the statement before printing or just send the statement directly to the printer. For now, leave the setting on **Preview** and click **Start**.
5. The program assembles the information and then displays the **Data Selection Questions** window. In each of the **Chart Number Range** fields, enter **SMI** and press **TAB** to print only Mr. Smith's statements. Click **OK**.
6. The statement is displayed in the **Preview Report** window. Click the Print Report speed button. Answer whatever questions you may need in the **Print** window, and then click **OK**.
7. Click **Close** in the **Preview Report** window. You may briefly see an **Update Billing Status** window and then are returned to **Statement Management** and the statement for Mr. Smith is printed. The statement status has been automatically changed to **Sent**, a batch number assigned, and the current date entered in the **Bill Date** column for both statements.

Changing Statement Status

1. Through **Statement Management**, all submitted statements are automatically marked **Sent** with an indication of the method of submission. The status needs to be changed when the statement is paid completely or for some other reason. Time has passed since you printed and sent the statements for John Smith and you have received a correction notice from the patient. You have already corrected the errors and are ready to resend the statements. To locate Mr. Smith's statements, we will use a different portion of the program. Click **List Only** and select John Smith's chart in the **Chart Number** field. Click **Apply**. In **Statement Management**, select the statement and click **Change Status**.
2. Select the **Batch** button and make sure the batch number in the box matches that shown in **Statement Management**.

NOTE: Since we used the **List Only Statements that Match** window to locate the statements, the batch number is automatically entered in the **Change Statement Status/Billing Method** window.

3. In the **Status From** section, choose **Sent**. In the **Status To** section, choose **Ready to Send**.

4. Click **OK**.
5. You are now ready to send the statements for John Smith again.
6. Click **Close** to close the **Statement Management** window.

Tutorial Practice 7 - Deposits

Creating a New Deposit

1. Click **Activities** and select **Enter Deposits/Payments**.
2. Click **New**.
3. The payer is A1 Insurance Partners, so be sure the **Payor Type** is **Insurance**. A1 Insurance Partners conveniently paid \$25 by check No. 5237; enter the check number in the **Check Number** field. The bank is United Southwest Savings. Enter the amount in the **Payment Amount** field.
4. In the **Insurance** field, select **A1 Insurance Partners**. Since you already set default codes when you set up the record for A1 Insurance Partners, the remaining fields are automatically filled. Click **Save**.

Deposit: (new)

Deposit Date: 2/1/2010

Payor Type: Insurance

Payment Method: Check Check Number: 5237

Description/Bank No: United Southwest Savings

Payment Amount: 25.00

Deposit Code: A

Insurance: A1000 A1 Insurance Partners (A1000)

Payment Code:	Code	Name	Street 1	City
	A1000	A1 Insurance Partners	11223	Harford
Adjustment Code:	AET00	Aetna	112 Aetna Way	Nowhere
	BLU00	Blue Cross Blue Shield 231	88 W. Bell Rd.	Phoenix
Withhold Code:	BLU01	Blue Cross Blue Shield 225	88 W. Bell Rd.	Phoenix
	CIG00	Cigna	2525 Big Bucks Ln.	Mesa
Deductible Code:	FHP00	FHP Health Plan	4576 E. W. Power Rd.	Mesa
	MED00	Medicaid	9875 W. Thunderbird	Glendale
Take Back Code:	MED01	Medicare	1111 1st Street	Alhambra

Save Cancel Help

- In the **Deposit List** window, be sure this new deposit is selected, and then click **Apply**.
- The **Apply Payments/Adjustments to Charges** window is opened. In the **For** field, select John Smith's chart.
- Locate the \$65 charge, click the **Payment** column of that record, and enter **20**. In the box below (part of the \$10.00 charge record), enter **5**. Click **Save Payments Adjustments** and then **Close**. A message is displayed letting you know that both claims will be marked "Done" for the primary carrier. (This is based on a selection made in **Program Options**.) If the **Print Statement Now** box is checked, the **Open Report** window is opened to select a statement form. You can print it, or click **Cancel**.

Apply Payment/Adjustments to Charges

A1 Insurance Partners Ins 1: **A1 Insurance Partners (A1000)** List Only... Unapplied Amount: \$0.00
 For: SMJ0000 Smith, John Ins 2: **FHP Health Plan (FHP00)** View So Far... ☒ Show Unpaid Only
 Ins 3:

Documentation Payment Procedure Codes: INSPAY DEDUC MCWH APWRD TAKEBA

	Date	Procedure	Charge	Remainder	Payment	Deductible	Withhold	Allowed	Adjustment	Take Back	Complete	Rejection	Provider
☒	02/01/2010	99214	65.00	30.00	-20.00			0.00			☒		KL
☒	02/01/2010	82954	10.00	10.00	-5.00			0.00			☒		KL

\$0.00 \$35.00 **\$-25.00** \$0.00 \$0.00 \$0.00 \$0.00 \$0.00

Options... There are 2 charge entries. ☒ Alert When Claims Are Done ☒ Alert When Statements Are Done ☒ Bill Remaining Insurances Now ☒ Print Statement Now ☐ Write off Balance Now

Save Payments/Adjustments Close View Transactions

8. Let's also assume that you receive a check from the secondary insurance carrier, FHP Health Plan. Create a new deposit for \$10.00 from FHP. The check number is 10890 and the bank is Greater Southwest Trust.
9. Click the deposit and click **Apply**. Select John Smith's chart. Apply \$8.00 to the \$65 charge and apply \$2.00 to the \$5.00 charge. Click **Save Payments/Adjustments** and click **OK** on the information window.

Apply Payment/Adjustments to Charges

FHP Health Plan Ins 1: **A1 Insurance Partners (A1000)** List Only... Unapplied Amount: \$0.00
 For: SMJ0000 Smith, John Ins 2: **FHP Health Plan (FHP00)** View So Far... ☒ Show Unpaid Only
 Ins 3:

Documentation Payment Procedure Codes: FHP DEDUC FHPWH FHPWR

	Date	Procedure	Charge	Remainder	Payment	Deductible	Withhold	Allowed	Adjustment	Take Back	Complete	Rejection	Provider
☒	02/01/2010	99214	65.00	22.00	-8.00			0.00			☒		KL
☒	02/01/2010	82954	10.00	5.00	-2.00			0.00			☒		KL

\$0.00 \$25.00 **\$-10.00** \$0.00 \$0.00 \$0.00 \$0.00 \$0.00

Options... There are 2 charge entries. ☒ Alert When Claims Are Done ☒ Alert When Statements Are Done ☒ Bill Remaining Insurances Now ☒ Print Statement Now ☐ Write off Balance Now

Save Payments/Adjustments Close View Transactions

10. If the **Print Statement Now** box is checked, the **Open Report** window is opened to select a statement form. You can print it, or click **Cancel**.
11. To review what you just did, click **Detail** in the **Deposit List** window.

12. The **Deposit Detail** window shows which transactions were affected and what was applied. This window is only for reviewing the details of a deposit. You cannot edit any transaction in this window.
13. If needed, you can print item details by selecting the line item and clicking print grid.
For more information, see:
F1 Look up Print an Entry from the Deposit List
14. Click **Close** after reviewing the details.
15. Click **Close** again to close the **Deposit List** window. If you return to the **Transaction Entry** window, a new entry has been created in the **Payments, Adjustments, And Comments** section—this insurance carrier payments.

Tutorial Practice 8 - Collections

Creating Collection List Items

Note: Be sure that you have activated security in your Medisoft program. Collections and Revenue will not work unless you have applied security.

1. Go to the **Activities** menu and select **Collection List**.
2. Click **New**.
3. In the Tickler tab, enter **Contact Attorney**.
4. Choose the **Patient** radio button.
5. In the **Chart Number** field, select John Smith's chart.
6. Select Mr. Smith also in the **Guarantor** and **Responsible Party** fields.
7. Choose the person to whom you want to assign this tickler. The names you see are those entered in the **Security Setup** window. If no names appear, you must set up Security first.
8. Choose **Open** as the status of the item.
9. By default, the follow-up date is today's date. Leave that date for now.
10. Click **Save**.
11. Let's create an insurance-responsible tickler also, so you can see the difference between the two. Click **New**.
12. In the Tickler tab, enter **Call insurance**.
13. Select **Insurance**.
14. In the **Chart Number** field, select John Smith's chart.
15. Select Mr. Smith's chart also in the **Guarantor** field.
16. Choose **AI Insurance Partners** in the **Responsible Party** field.
17. Choose the person to whom you want to assign this tickler.
18. Choose **Open** as the status of the item.
19. By default, the follow-up date is today's date. Leave that date for now.
20. Click **Save**.

Adding a Collection List Item

1. Go to the **Activities** menu and select **Add Collection List Item**.
2. Choose the **Claims** radio button.
3. Click the **Primary** radio button in the **Carriers** field.
4. Click the **Rejected** radio button.
5. Select **A1 Insurance Partners** for the first **Insurances** field and **FHP Health Plan** in the second **Insurances** field.
6. Enter **2** in the **Add item if submission count is great than** field.
7. Assign the item to **Pat Smith**.
8. Check the **Add Billing Comment to Office Notes** check box.
9. Click **Add Items**.
10. Click **No**.

Patient Payment Plans

1. Go to the **Lists** menu and select **Patient Payment Plan**.
2. Click **New**.
3. In the **Code** field, enter **A**.
4. In **Description** enter 5/30 (signifying a plan to pay \$5 dollars every 30 days).
5. In **First Payment Due**, enter **5** to have payments due on the 5th of every month.
6. In **Due Every ... days** enter **30**.
7. Enter **5** in the **Amount Due** field.
8. Click **Save**.
9. Close the **Patient Payment Plan List** window.
10. Go to the **Lists** menu and select **Patients/Guarantors and Cases**.
11. Find John Smith's record, select it, and click **Edit Patient**.
12. Open the Payment Plan tab.
13. In **Payment Code** select plan **A**.
14. Click **Save**. Click **Close**.

Mr. Smith is now assigned to a payment plan. If he makes payment of the correct amount and in the prescribed time, he will not be receiving collection letters from your practice.

Collection Letters

Collection Letters

1. Go to the **Reports** menu and select **Collection Reports**, then **Patient Collection Letters**.
2. Click **Start** in the **Print Report Where?** window.
3. In the **Collection Letter Report: Data Selection Questions** window, skip the range fields and click **Exclude items that follow Payment Plan**.
4. Click **Generate Collection Letters**. This also activates and enables the **Add To Collection Tracer** field. Keep this field clicked. Then click **OK**.

5. Preview the report, and then click **Close** (unless you really want to print it first).
6. When asked if you want to print collection letters, click **Yes**.
7. Select the **Collection Letter** format (or any customized format available) and click **OK**.
8. Click **Start** to preview the letters.
9. Review the letters and print them.
10. When you open an account in **Transaction Entry**, **Quick Ledger**, **Quick Balance**, or an **Appointment** window, the words "Account alert" appear near the patient's name to indicate that the account is in collections.

Customizing Collection Letters

1. Go to the **Tools** menu and select **Collection Letter Wizard**.
2. Choose the **Third-Party Address** radio button. The **Third-Party Billing Information** section opens at the bottom of the window.
3. In the other fields enter **Happy Valley Associates, 9825 W. Baseline Road, Suite 263, Gilbert, AZ 85234, 480-111-2222**.
4. In **Sender Name** choose **Provider**.
5. Click **Preview**.
6. After previewing the sample letter, click **Create**. A little box appears in the middle of the window stating that the format is being updated. Then a confirmation box displays. Click **OK**. The wizard closes.
7. A new collection letter format has been created. You will see it the next time you create collection letters. It is called WzCollections **date**. For example, if today's date were February 2, 2010 and you customized the format today, the format would be called "WzCollections120304."

NOTE: If you create multiple customized versions of the collection letter format, you might want to keep a list somewhere noting the date and a note concerning what was customized.

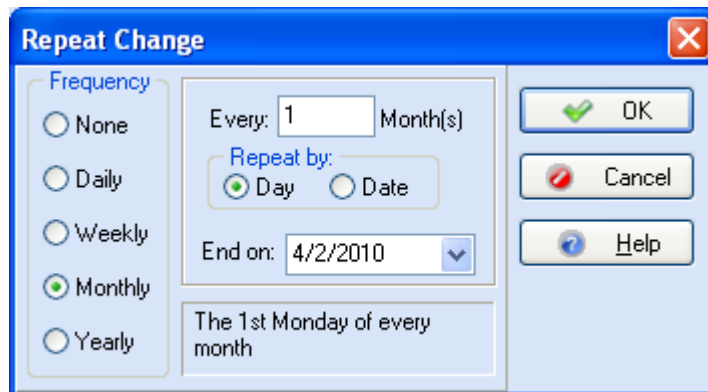
Writing off Small-Balances

1. Go to the **Activities** menu and select **Small Balance Write-off**.
2. Leave the button set to **All** in the **Patient Selection** field.
3. Select **CABADDEBT** in the **Write-off Code** field.
4. Enter **1/12/06** in the **Cutoff Date** field.
5. Enter **150.00** in the Maximum Amount field.
6. Click **Apply**. Click **OK** on the **Confirm** window.
7. Select **Selected Items** in the **Write off** field.
8. Hold down **CTRL** and click the patient record for **Sammy Catera** and **James Doogan**.
9. Click **Write off**.
10. Click **Close**.

Tutorial Practice 9 - Office Hours

Entering Resources

1. Go to the **Lists** menu and select **Resource List**. Click **New**.
2. Leave the **Code** field blank. In the **Description** field enter **Treadmill**. Click **Save**. Click **Close**.



Repeat Change

Frequency:

- ☐ None
- ☐ Daily
- ☐ Weekly
- ☒ Monthly
- ☐ Yearly

Every: 1 Month(s)

Repeat by:

- ☒ Day
- ☐ Date

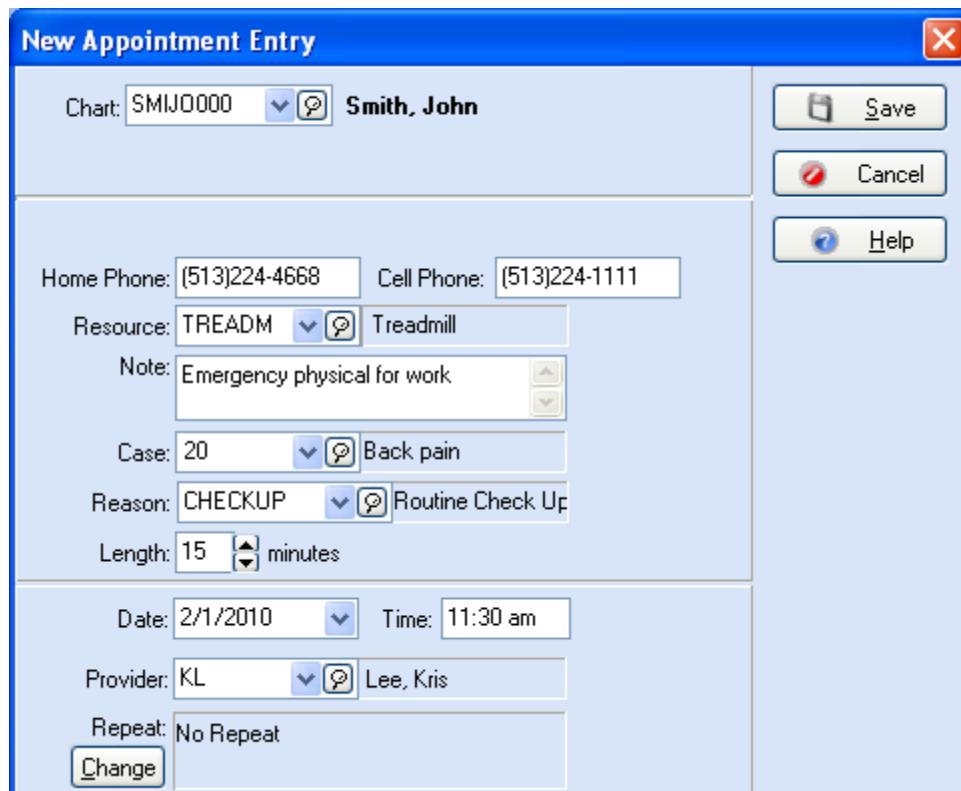
End on: 4/2/2010

The 1st Monday of every month

OK Cancel Help

Entering Appointments

1. John Smith calls and needs to see Dr. Lee today. Dr. Lee actually has an opening at 11:30 am. In all views except Monthly (Advanced and above) and Multi View (Advanced and above), select Dr. Lee in the provider box to the right of the Exit speed button in the toolbar. In any Multi View, be sure to locate Dr. Lee's appointment column. You see that the 11:30 time slot is open for Dr. Lee so double-click it to open the **New Appointment Entry** window.



New Appointment Entry

Chart: SMIJ0000 Smith, John

Home Phone: (513)224-4668 Cell Phone: (513)224-1111

Resource: TREADM Treadmill

Note: Emergency physical for work

Case: 20 Back pain

Reason: CHECKUP Routine Check Up

Length: 15 minutes

Date: 2/1/2010 Time: 11:30 am

Provider: KL Lee, Kris

Repeat: No Repeat

Change

Save Cancel Help

2. In the **Chart** field, select John Smith. Press **ENTER**. In **Resource**, enter **T** to help locate the treadmill resource. Highlight the correct resource and press **ENTER**.
3. In the **Note** field, enter the following information: **Emergency physical for work**.

4. The **Case** defaults to Mr. Smith's most recently opened case. In the **Reason** field, although we have not yet created reasons of our own, we can select one from the database. Click the down arrow and select **Routine Checkup**.
5. The date and time have already been selected, so click **Save**. See that Mr. Smith's name appears in the 11:30 am slot. Also notice that it is fuchsia in color (which is the color assigned to the Routine Checkup reason). A recap of the appointment and Mr. Smith's information is also displayed to the left of the Appointment Grid.

Repeating Appointments

1. Dr. Lee wants to follow up on Mr. Smith's treadmill results and asks you to make two more appointments, a month apart. Since 11:30 am is a good time for Mr. Smith, double-click the existing appointment.
2. In the bottom left corner of the **Edit Appointment** window, click **Change** to open the **Repeat Change** window. Choose **Monthly**. In the **End on:** field, click the down arrow to show the calendar. Click the right arrow twice (for two months). Then click **OK**. Click **Save**.

Setting Breaks

1. Click the Break Entry speed button. In the **Name** field, enter **Dr. Lee Seminar**.
2. The meeting is scheduled for two hours on June 21, starting at 1:00 pm. In the **Date** field, enter **11/20/2009**. For **Time**, type in **1:00 p**. In **Length** type **120**. In **Resource** enter **L** for the Lunch room. Give it an aqua color, using the down arrow to display the color choices. Click the **All Columns** box to be sure everyone participates. Under **Provider**, choose **All**. Click **Save**. To double-check, click the appropriate **Month** and **Day** buttons to locate November 20, 2009. If necessary, use the scroll bar to show the seminar.
3. To return to today's calendar, click the Go to Today speed button.

Creating Reason Codes

1. Go to the **Lists** menu and select **Reasons List**. Click **New** to open the **Appointment Reason Entry** window.
2. Leave the **Code** field blank. In the **Description** field, enter **Sports Accident**.
3. The default appointment length is 15 minutes. Change this number to 30. In the **Default Appointment Color** field, the drop-down arrow lets you select a color that fills the appointment space on the schedule grid. Choose red for this emergency accident response. In **Default Template Color** (Advanced and above), select **Light Red**. Click **Save**.

Creating Templates

NOTE: This is an Office Hours Professional feature.

1. Go to the **Lists** menu and select **Templates List**. Click **New**.
2. In one of the six **Template Reasons** fields, use the drop-down arrow to enter **NEW** in the **Code** field. In the **Description** field describe the template's use as **See New Patients**. Using the drop-down arrows, select Dr. Lee as the **Provider**, and the **Resource** is Exam Room 2.
3. Click the arrow on the **Date** field to display the calendar and highlight the designated date. Use the arrows on either side of the month name to change to an earlier or later month, if necessary. Type **10:00 a** in the **Time** field. Set the **Length** to 120. The search arrow on the **Color** field lets you select light yellow as the color for the template on the appointment grid.
4. You want to use this template every day, so click **Change** to display the **Repeat Change** window. Choose the **Weekly** frequency, enter the number 1, and click the boxes for **Tuesday** and **Thursday**. Leave the **End on** field blank at this time. Your entry is confirmed with the message, "Every week on Tue and Thu."

Creating Multi Views

NOTE: This is an Office Hours Professional feature.

1. Dr. Lee works only with therapy patients and uses Exam Room 2 for consultations. Let's create a view where you can see all of these schedules at the same time.
2. To create a multi view, go to the **File** menu and select **Program Options**. Open the Multi Views tab. Click **New**.
3. Name the new view **Dr. Lee** and press **TAB**. In the **Type** field, click the box and select **Provider**. In the **Code** field, locate and highlight Dr. Lee's name. Leave the **Width** at its default setting. Click **Insert Column**.
4. In the next line, select the **Resource** type. Press **TAB**. Locate Exam Room 2 and highlight it. Press **TAB**. Change the **Width** column to 50. Click **Insert Column** to create a new line. Again select **Resource**. This time locate and select **Therapy**. Click **Close**. Click **OK**.

Using the Wait List

NOTE: This is an Office Hours Professional feature.

1. Mr. Smith has seen the doctor for his injury but he needs a return visit in a week. With the full appointment schedule, the surest way to work him in is to put him on the Wait List. Go to the **View** menu and click **Wait List**. Click **New**.
2. Select John Smith from the **Chart number** field. Click **Save**.
3. To begin the search for his next appointment, highlight his record and click **Find** to open the **Find Open Time** window.
4. Mr. Smith is out of school at 2 p.m. but has choir practice on Tuesday and Thursday. He needs a 15 minute appointment so enter a **Start Time** of **2:30 p** and an **End Time** of **5:00 p**. Click **Monday**, **Wednesday**, and **Friday**. Click **Search** and let it go. In a few moments, if the program finds a match, a **Confirm** window pops up: "Open time slot found. Do you want to set the appointment?" If the first time slot it presents is not satisfactory, click **Retry** and let it search further. Or click **Yes** and schedule the appointment.

Tutorial Practice 10 - Modifying the CMS 1500 Form

Repositioning the CMS-1500 form

1. Let's say your paper claims are printing with text shifted too far to the right and below the spaces provided in the pre-printed CMS-1500 forms.
2. Go to the **Reports** menu and select **Design Custom Reports and Bills**. Click the Open speed button (the book with the arrow pointing to it) and select **CMS - 1500 (Primary)**. Click **OK**.
3. Go to the **File** menu and select **Report Properties**.
4. It's probably better to make one adjustment at a time, so in the **Form Offset** section, and change **Left** to **.05**. Click **OK**.

The screenshot shows the 'Report Properties' dialog box with the 'General' tab selected. The 'Report Title' is 'CMS - 1500 (Primary)'. The 'Margins (Inches)' section has 'Left' at 0.25, 'Right' at 0.25, 'Top' at 0.25, and 'Bottom' at 0.25. The 'Form Offset' section has 'Left' at 0.05 and 'Top' at -0.08, both in inches. The 'Paper Size' is 'Letter' and 'Page Orientation' is 'Portrait'. The 'Insurance Claim Type' section has 'Primary Claim' selected. The 'Export To Text Options' section has 'Lines Per Page' set to 66, 'Mark Billed' checked, 'Tracer' unchecked, 'Columns' set to 1, 'Uppercase Text' checked, and 'Include title page with data filters' unchecked. The 'Guarantor Statement Grouping' section has 'Group Transactions by Revenue Code' unchecked, with 'Date Included' and 'Date Excluded' options. The bottom of the dialog shows 'Date Created: 5/13/3896 11:04:15 AM', 'Date Last Modified: 10/27/2009 9:57:26 PM', 'File Name: mmins13.mre', and 'Report Style: Insurance Form'. On the right side, there are buttons for 'OK', 'Cancel', 'Help', and 'Convert'.

5. You need to print the form to see if it is adjusted enough. Click the Print speed button. The **Save Report As...** window is displayed. Since you are revising a standard form, give this form a different name, until you know it is correct. In the **Report Title** box, enter **CMS - 1500 1**.

TIP: You need to use a name that you can remember, but you cannot replace the original form. If you use the same name as the original form, the list shows two forms with the same name and it may be difficult to remember which is the form you have revised.

6. The program informs you that claims and statements printed through the Report Designer are not marked as billed. This is generally a good thing. Click **OK**.
7. In the **Data Selection Questions** window, select a single claim number in the **Claim Number Range** so only one page prints. Click **OK**.

TIP: Use the **Claim Number Range** and not the **Chart Number** range because there must be an available claim before the form prints from the Report Designer.

8. Click **OK** in the **Print** window. We made a great adjustment and the right/left adjustment is perfect.
9. Now repeat the process, opening the **Report Properties** window. This time, enter **.6** in the **Top** field. Click **OK**.
10. Again print the form and check to see if the alignment is OK.
11. Unfortunately, aligning the CMS- 1500 form is a trial-and-error process. You may have to make a number of adjustments to get the printing just right. When you do get the adjustments right, save the form and close the Report Designer. Use this revised form each time you print paper claims.
12. If you are short on CSM-1500 forms, you can print the report on plain paper. Place the test paper on top of a pre-printed form and hold them up to the light to see if the text is lined up properly.

How To Revise an Existing Report

1. You decide that you want the Zip Code included on your patient lists. In the Report Designer, click the Open speed button. Locate **Patient List** and click **OK**.
2. First you need to add the column heading and you have to make a little space for it. Move the **Phone** heading a little to the right by clicking and dragging the field. (This is the heading in the blue band, not the one in the green band.)
3. Click the Text Field speed button in the toolbar and then click the cursor in the space between **CityLine** and **Phone**. Double-click this new text field to open the **Text Properties** window. In the **Text** field, enter **Zip Code**. Click **Font** and, in **Font style**, click **Bold**. Click **OK**. Click **OK** again. To be sure the heading is aligned properly, hold down the **Shift** key and click **CityLine**, **Zip Code**, and **Phone**. Right-click over one of the selected fields and select **Align Fields** in the Speed menu.
4. In the **Alignment** window, choose **Bottoms** and click **OK**. You're halfway there!
5. In order to align the **Phone** heading and the **Phone 1** field (in the green band), right-click **Phone** and select **Properties**. In the **Text Properties** window, locate and make note of the value in the **Position Left** field. Click **OK**. Now, right-click over the **Phone 1** field and enter the same value in the **Position Left** field of this window. Click **OK**. The **Phone** heading and **Phone 1** field are now aligned.
6. Next you need to enter the Zip Code field in the document; you need to insert a Data Field in the green band. Click the Data Field speed button, and then click the green band below the **Zip Code** heading.
7. Double-click this new field to open the **Data Field Properties** window. Click **New Data Field**. In the **Select Data Field** window, the **Patient** file should automatically be selected. Be sure it is. In the **Fields** section, scroll down until you see **Zip Code**. Select **Zip Code** and click **OK**. Click **OK** again.

8. To make sure the two Zip Code fields are aligned, right-click over the heading and make note of the value in the **Left** position field. Then right-click over the Zip Code field (green band) and enter the same number in the corresponding field of this window.
9. To save, you must rename the form. Go to the **File** menu and select **Save As**. In the **Report Title** box, enter **Patient List w/Zip** and click **OK**. Close the Report Designer.
10. To test your new report form, go to the **Reports** menu and select **Patient List w/Zip**.

How To Create a New Report

1. Choose a report style on which to base a completely new form.
2. Format the report by going to the **File** menu and selecting **Report Properties**. Establish the report name, margins, size of bands and filter the source data needed to provide the information for the report.
3. With the report formatted, you can begin placing fields on the grid. Make the necessary additions and/or changes to complete your form, then save and exit Report Designer. The new report appears in the Custom Report List.
4. As you become familiar with the workings of Report Designer, formatting and designing become easier.

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